

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

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MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01419

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY in 1b <b>Mrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>		d. STREET ADDRESS <b>25 Bunch St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>WILLIAM</b> Last <b>ADAMS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1962</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 24-1909</b>		9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bar Tender</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles E. Adams</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta - Hebron</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-0801</b>		17. INFORMANT <b>Charles G. Adams - 16 Carver St. Anna, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 acute Pulmonary Edema</b> DUE TO (b) <b>Myocardial infarction ? x</b> DUE TO (c) <b>Arteriosclerotic CVD</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 hr</b> <b>3 hr.</b> <b>5 yr.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>was present</del> ) attended the deceased from <b>Feb. 2, 1962</b> , to <b>Feb. 2, 1962</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Feb. 2, 1962</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank M. Shipley</b>				22b. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>		22c. DATE SIGNED <b>2-2-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frank M. Shipley</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>		22e. REC'D BY REGISTRAR <b>FEB 13 '62</b>		22f. REGISTRAR'S SIGNATURE <b>William S. Finney</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 5-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hicks III</b>				24b. ADDRESS <b>Annapolis, Maryland</b>			

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01420

01437

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>Few minutes</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie</u> d. STREET ADDRESS <u>Route 2 Box 847</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Emmett Swindel Armstrong</u> First Middle Last 4. DATE OF DEATH <u>February 7th 1962</u> Month Day Year		<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>7/13/00</u> <b>9. AGE</b> (In years lost birthday) <u>61</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Molds Maker in a Glass Factory</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore, Md.</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>USA</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>?</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>?</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Mrs Jennie Lee (daughter)</u> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitral Insufficiency</u> 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>September 1961</u> <b>to</b> <u>February 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2/6/62</u> <b>and that death occurred</b> <u>8:50A M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Gustave H. Faubert M.D.</u> <b>22b. DATE</b> <u>2/7/62</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Gustave H. Faubert, M.D.</u> <b>22d. ADDRESS</b> <u>Glen Burnie, Md.</u>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>2/10/62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Meadowridge Mem. Cem.</u> <b>23d. LOCATION</b> (City, town, or county) (State) <u>Elkridge, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>JOHN F. DENNY, INC.</u> <b>25a. REC'D BY REGISTRAR</b> <u>FEB 9 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Harris</u>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01433  
CERTIFICATE OF DEATH  
01421

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN b. <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNE ARUNDEL GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS - BAY RIDGE</u> d. STREET ADDRESS <u>14 E. LAKE DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>TAMARA SUE BALL</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 19-1958</u>
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE L. BALL</u>		14. MOTHER'S MAIDEN NAME <u>MILDRED ANN BRANHAM</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>GEORGE L. BALL</u>		18. ADDRESS <u>14 E. LAKE DRIVE ANNAPOLIS MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Streptococcal Meningitis &amp; Septicemia</u> 053.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>053.0</u> (c) DUE TO <u>053.0</u> (e), stating the underlying cause last. (c) <u>053.0</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>0</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/16/62</u> to <u>2/17</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/17</u> , 19 <u>62</u> , and that death occurred at <u>12</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Philip Briscoe</u> M.D.		22b. DATE SIGNED <u>FEB 17, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>PHILIP BRISCOE</u>		22d. ADDRESS <u>95 CATHEDRAL ST. ANNAPOLIS MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-20-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>		25a. REC'D BY REGISTRAR <u>FEB 20 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01439						01422					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <b>Anne Arundel</b>			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>			c. LENGTH OF STAY IN 1b <b>14 days</b>			d. STREET ADDRESS <b>1307 N. Central Avenue</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Ella W. Bazemore</b>			4. DATE OF DEATH <b>2 13 19 62</b>								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 11, 1885</b>		9. AGE (In years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Whitt Watson</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>522 X</b> DUE TO <b>Hypostatic Pneumonia</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>Senility due to Chronic Brain Syndrome</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dehydration, Inanition and Uremia</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>							
20c. TIME OF INJURY Hour a.m. p.m. <b>----- 19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b>		20g. (County) <b>-----</b>		20h. (State) <b>-----</b>	
21. I certify that (I) (his hospital) attended the deceased from <b>1/29</b> , 19 <b>62</b> , to <b>2/13</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> , 19 <b>62</b> , and that death occurred at <b>6:30 P.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Lionel McHenry Mapp, M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/14/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>						22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/27/62</b>				23b. DATE THEREOF <b>2/27/62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary</b>			
23d. LOCATION (City, town or county) <b>Anne Arundel</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>A. Halstead</b>				ADDRESS <b>918 Druid Hill Ave</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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CERTIFICATE OF DEATH

Reg. D. 01423

01440

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>		c. LENGTH OF STAY IN 1b <b>10 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RIDGEBROOK ARMY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>BIRD</b> Last <b>BIRD</b>		4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Feb 1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	9. AGE (In years last birthday) <b>83</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Son, Lt Col Edward Bird (Retired)</b> Address <b>Same as item 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio vascular accident</b> 4-2-2-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> (c) <b>Unknown</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>3 Feb</b> , 19 <b>62</b> , to <b>12 Feb</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>12 Feb</b> , 19 <b>62</b> , and that death occurred at <b>3:15 A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>12 Feb 62</b>			
ACTUAL SIGNATURE <i>Rafael A. Perez-Mera</i> M.D.		12 Feb 62	
PHYSICIAN'S NAME (Type) <b>RAFAEL A. PEREZ-MERA, Capt., M.C. KAH Ft Geo G. Meade, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-14-1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Glen Burnie Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert P. Ware</i> REGISTERED FUNERAL HOME ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 15 '62</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>

(M)

50

(I)

0

BP

13-419

WINTER OF 1941

13-419



*[Faint, mostly illegible handwritten text covering the majority of the page. The text appears to be organized into several paragraphs or sections, but the specific words are difficult to discern due to fading.]*

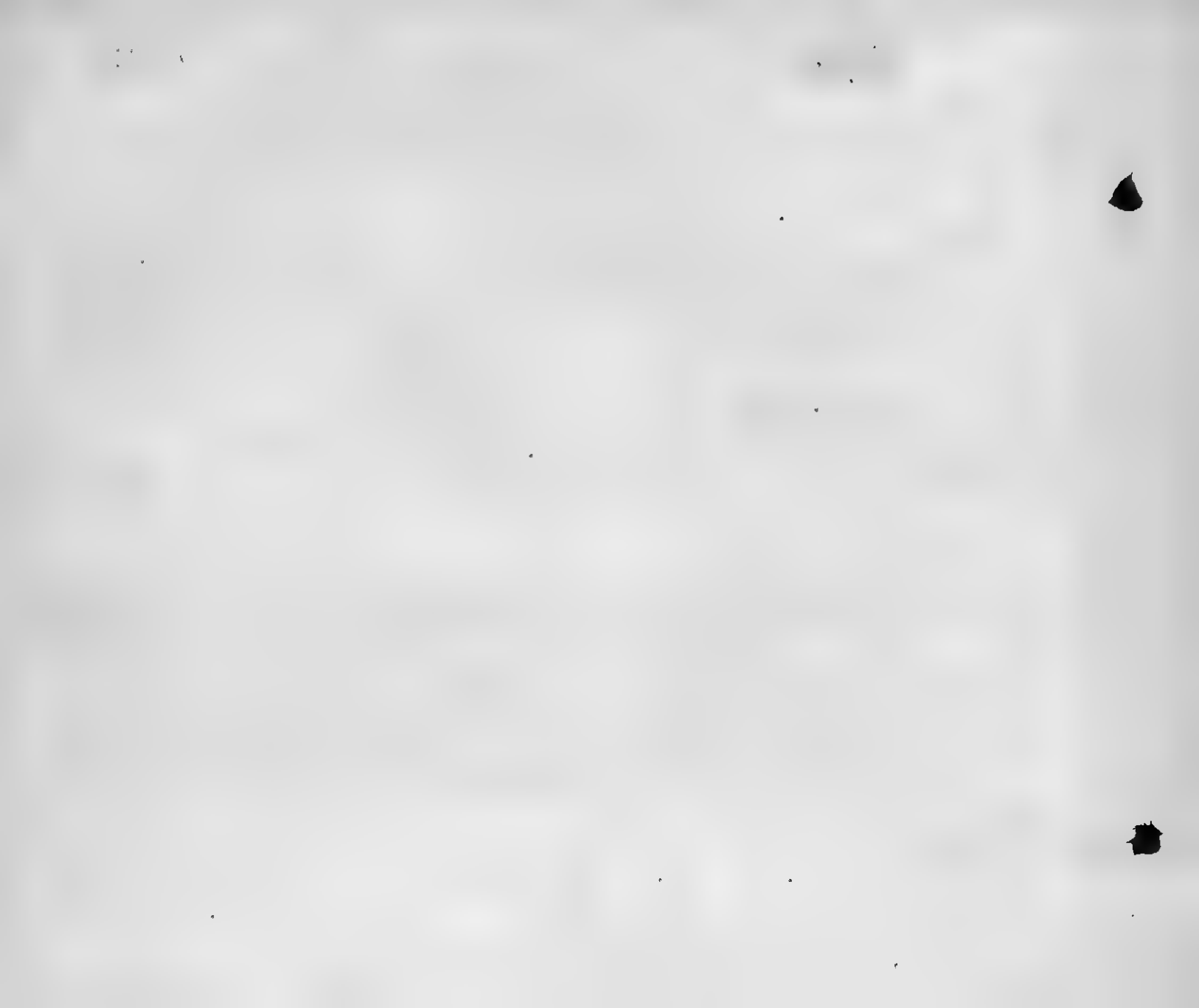
1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**01441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01424**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN b. <b>5 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 134 Salley Rd.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Same</b> d. STREET ADDRESS <b>Same</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Grace Dorworth Bowdoin</b>		4. DATE OF DEATH Month Day Year <b>February 13th. 19 62</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/8/77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>84</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis O. Mosher</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Shoemaker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Laurence Bowdoin (son)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		DATE SIGNED <b>2/14/62</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 15, 1962</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pinewood Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR <b>Wm. Cook, Inc. 1217 St. Paul St.</b>		24a. REC'D BY REGISTRAR <b>FEB 19 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>C. W. &amp; H. H.</b>			



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01442

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01425

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b>		c. LENGTH OF STAY IN 1b <b>16 Y.</b>		2. USUAL RESIDENCE (Where deceased lived, if institut on; Residence before admitt on) a. STATE <b>Same</b>		b. COUNTY <b>Same</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>		d. STREET ADDRESS <b>Same</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Paul I. Bowen</b>		4. DATE OF DEATH <b>February 9th, 19 62</b>		5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/25/04</b>		9. AGE (In years last birthday) <b>57</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Automobile Dealer</b>		11. BIRTHPLACE (State or foreign country) <b>Cavanaugh, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Bowen</b>		14. MOTHER'S MAIDEN NAME <b>Mellie Crum</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Dorothy Hilda Bowen (wife)</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>DUE TO</b> c) <b>DUE TO</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>		EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>2/9/62</b>		Address (Street, city, town, or county) <b>Glen Burnie, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-13-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		22d. LOCATION (City, town, or county) <b>Glen Burnie, Md.</b>		23. FUNERAL DIRECTOR <b>Robert S. Baranec</b>		ADDRESS <b>Severna Park, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 13 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>					

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01443					01426									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY		Anne Arundel			a. STATE		b. COUNTY							
		MARYLAND			Maryland		Talbot							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
Crownsville		1 mo. 2 days			Easton									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS									
Crownsville State Hospital					?									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. SEX							
First Middle Last					Month Day Year		Female							
Maggie					2 19 1962		Branch							
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.						
Female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		March 10, 1883		78						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
Domestic			-----			Virginia			U.S.A.					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
Nelson Branch					Mary									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
Unknown					Unknown					Hospital Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
Hypertensive Cardiovascular Disease														
f.i.s.x. DUE TO														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Chronic Brain Syndrome Associated with Arteriosclerosis														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)									
-----														
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
Hour a.m. ----- p.m. -----			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		-----			-----						
21. I certify that (I) (this hospital) attended the deceased from 1/17, 1962 to 2/19, 1962, that (I) (we) last saw the deceased alive on 2/19, 1962, and that death occurred at 8:45 PM, from the causes and on the date stated above.														
22a. SIGNATURE					22b. DATE SIGNED									
L. Benedict, M. D.					2/20/62									
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS									
L. Benedict, M. D.					Crownsville State Hospital, Maryland									
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)						
Removal			3-1-62		Univ. of Md. Med. Sch. Balt.			Md.						
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Wm. Fee II					ADDRESS					DATE 5 '62				
Annapolis, Md.														

15 1

15 1



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 01444 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01427

FOR STATE HEALTH DEPT.

### 1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Anne Arundel General Hospital

### 3. NAME OF DECEASED

(Type or print)

First HAROLD

Middle D.

Last BRITTON

### 5. SEX

Male

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

12-28-1912

9. AGE (In years last birthday) 49 yrs.

10. IF UNDER 1 YEAR Months Days

11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Rating Clerk

10b. KIND OF BUSINESS OR INDUSTRY

Gas & Electric Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

### 13. FATHER'S NAME

William A. Britton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Dorothy M. Pike-2797 Yarnall Road-Sunset Hill

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Carbon Monoxide Intoxication.

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Ran hose from exhaust pipe into auto.

20c. TIME OF INJURY Hour a.m. p.m. 2/14 19 62

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Lodge

20f. (City or town)

St. Margaret

(County)

A.A.

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town or country)

DATE SIGNED

2/15/62

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

2-19-62

22c. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

22d. LOCATION (City, town, or country)

Baltimore, Md.

### 23. FUNERAL DIRECTOR

Wm J. Zick

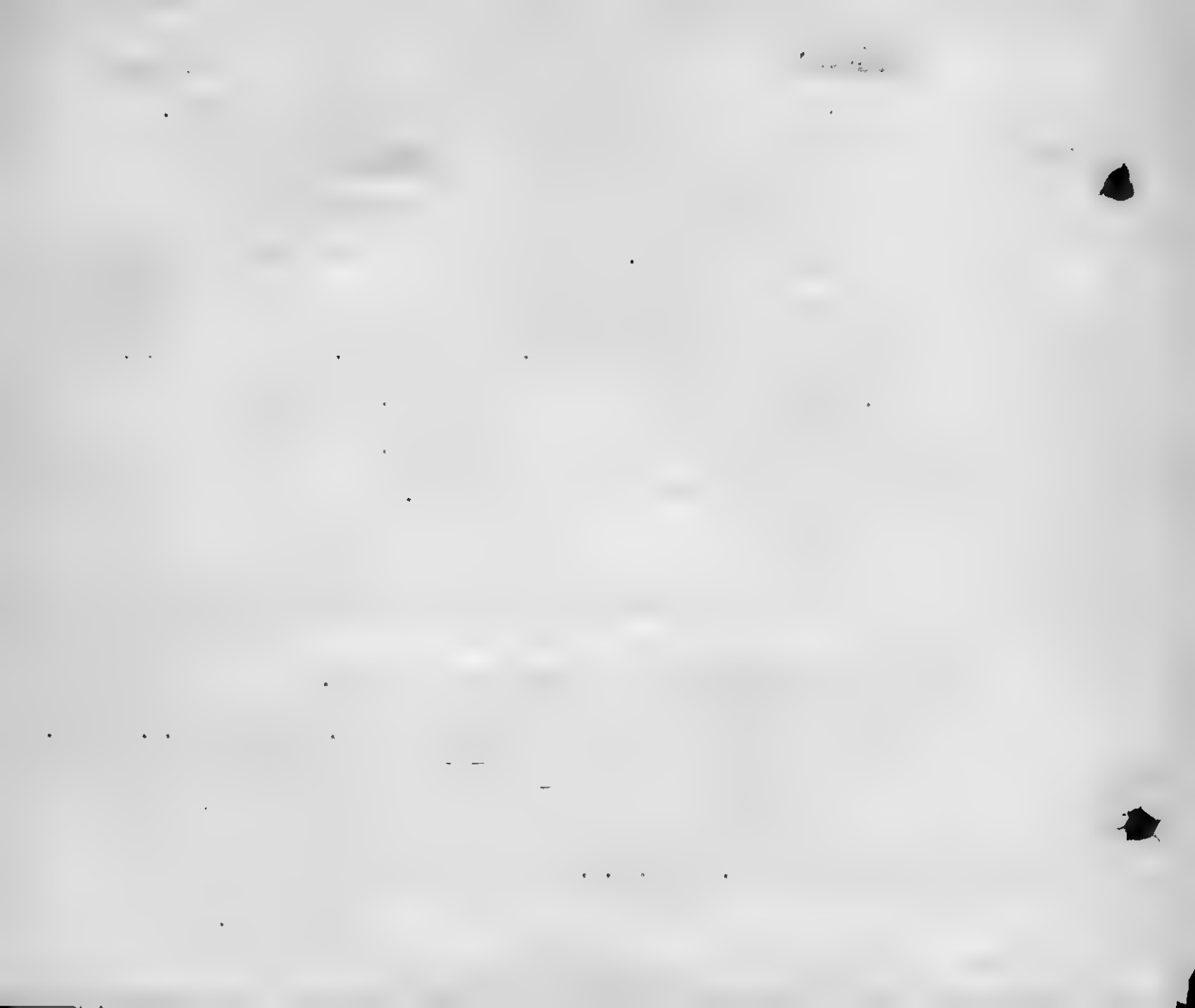
24a. REC'D BY REGISTRAR

DATE FEB 16 '62

24b. REGISTRAR'S SIGNATURE

Wm J. Zick

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01445

CERTIFICATE OF DEATH

01429

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>32 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Churchton</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Richard</u> Middle <u>Earl</u> Last <u>BROWN</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>13</u> Year <u>1962</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>February 12, 1962</u>		<b>9. AGE</b> (In years last birthday) <u>1</u> <b>IF UNDER 1 YEAR</b> Months <u>1</u> Days <u>8</u> Hours <u>50</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			
<b>13. FATHER'S NAME</b> <u>Richard Earl JOHN</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Barbara Lola BROWN</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>(If yes give year or dates of service)</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Hospital records</u>			
<b>17. INFORMANT</b> <u>Hospital records</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - 26 weeks gestation.</u> 161.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Retroplacental hemorrhage.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) _____		<b>INTERVAL BETWEEN ONSET AND DEATH</b> _____	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____		<b>(County)</b> _____			
<b>(State)</b> _____		<b>21. I certify that (I) (M.D.)</b> <u>Oct 1962</u> <b>attended the deceased from</b> <u>Feb. 12, 1962</u> , <b>to</b> <u>Feb. 13, 1962</u> , <b>that (I) (M.D.)</b> <u>last</u> <b>saw the deceased alive on</b> <u>Feb. 12, 1962</u> , <b>and that death occurred at</b> <u>9:30 AM</u> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Lionel McH. MAPP</u>		<b>22b. DATE SIGNED</b> <u>2/13/62</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Lionel McH. MAPP, M.D.</u>		<b>22d. ADDRESS</b> <u>20 Dean St., Annapolis, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Buried</u>		<b>23b. DATE THEREOF</b> <u>Feb 14, 1962</u>			
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hollano Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> <u>Churchton</u>			
<b>23e. (State)</b> <u>Md</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>T A Hardesty + Son</u>			
<b>24a. ADDRESS</b> <u>Galesville Md</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE FEB 19 '62</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. Aug 8. Kraus</u>		<b>25c. (State)</b> <u>Md</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01446

CERTIFICATE OF DEATH

01431

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>610 Second St. (Eastport)</u>	
3. NAME OF DECEASED (Type or print) <u>George</u> First Middle Last 4. DATE OF DEATH <u>February 5 1962</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 16, 1872</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>89</u> yrs. <u>5</u> Months <u>19</u> Days <u>62</u> Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Elizabeth Butts</u>		14. MOTHER'S MAIDEN NAME <u>Henry Butts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Simath Butts, Annapolis, Md</u>	
17. INFORMANT <u>Simath Butts, Annapolis, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>A.P.H.D. with long term fibrill</u> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 years 3 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter no use of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>Herlino</u> attended the deceased from <u>Feb. 4, 1962</u> , to <u>Feb. 4, 1962</u> that (I) <u>yes</u> last saw the deceased alive on <u>Feb. 4, 1962</u> , and that death occurred at <u>3:45 AM</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>H. T. O'HERLINO</u>		22b. DATE SIGNED <u>2/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. T. O'HERLINO</u>		22d. ADDRESS <u>5 Central Ave., Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Annapolis</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James J. ...</u>		25a. REC'D BY REGISTRAR <u>Feb 9 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. ...</u>			



1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01447

CERTIFICATE OF DEATH

01432

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>		c. LENGTH OF STAY IN 1b <b>5 hrs 25 min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KIMBROUGH ARMY HOSPITAL</b>		d. STREET ADDRESS <b>5216 Cromarty Road</b>	
3. NAME OF DECEASED (Type or print) First <b>GARY</b> Middle <b>MICHAEL</b> Last <b>CALDWELL</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>9</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 Feb 62</b>
9. AGE (In years last birthday) <b>5</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>25</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert X Caldwell</b>		14. MOTHER'S MAIDEN NAME <b>Nora Isabel Evers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Father</b>		Address <b>Same as item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unknown</b> <b>776X</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>-</b> DUE TO (c) <b>-</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs 25 min</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <b>-</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>9 Feb 1962</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Stuart Bernstein</b> attended the deceased from <b>9 Feb 1962</b> to <b>9 Feb 1962</b> that (I) <b>yes</b> saw the deceased alive on <b>9 Feb 1962</b> , and that death occurred at <b>8:00 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stuart Bernstein</b>		22b. DATE SIGNED <b>9 Feb 62</b>	
22c. PHYSICIAN'S NAME <b>STUART BERNSTEIN, Capt., M.C.</b>		22d. ADDRESS <b>Kimrough Army Hosp Ft Geo G. Meade, Md</b>	
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF <b>11/1/62</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Stuart Bernstein</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 14 '62</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7 61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

1. PLACE OF DEATH  
a. COUNTY Anne Arundel MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)  
e. STATE Maryland b. COUNTY Anne Arundel  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis  
d. STREET ADDRESS 59 Shaw Street

3. NAME OF DECEASED (Type or print) Rachel First Middle  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒  
4. DATE OF DEATH February 2 1962 Month Day Year

5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 2/19/87 9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work considering most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 10b. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME George Miller 14. MOTHER'S MAIDEN NAME Ellen M. Neal

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name or unknown) No 16. SOCIAL SECURITY NO. 101-1-62-2 17. INFORMANT William K. Reese Address 57 Shaw Street

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Dementia Arteriosclerotic  
+ SIX DUE TO with rupture  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) with rupture  
(c) with rupture

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

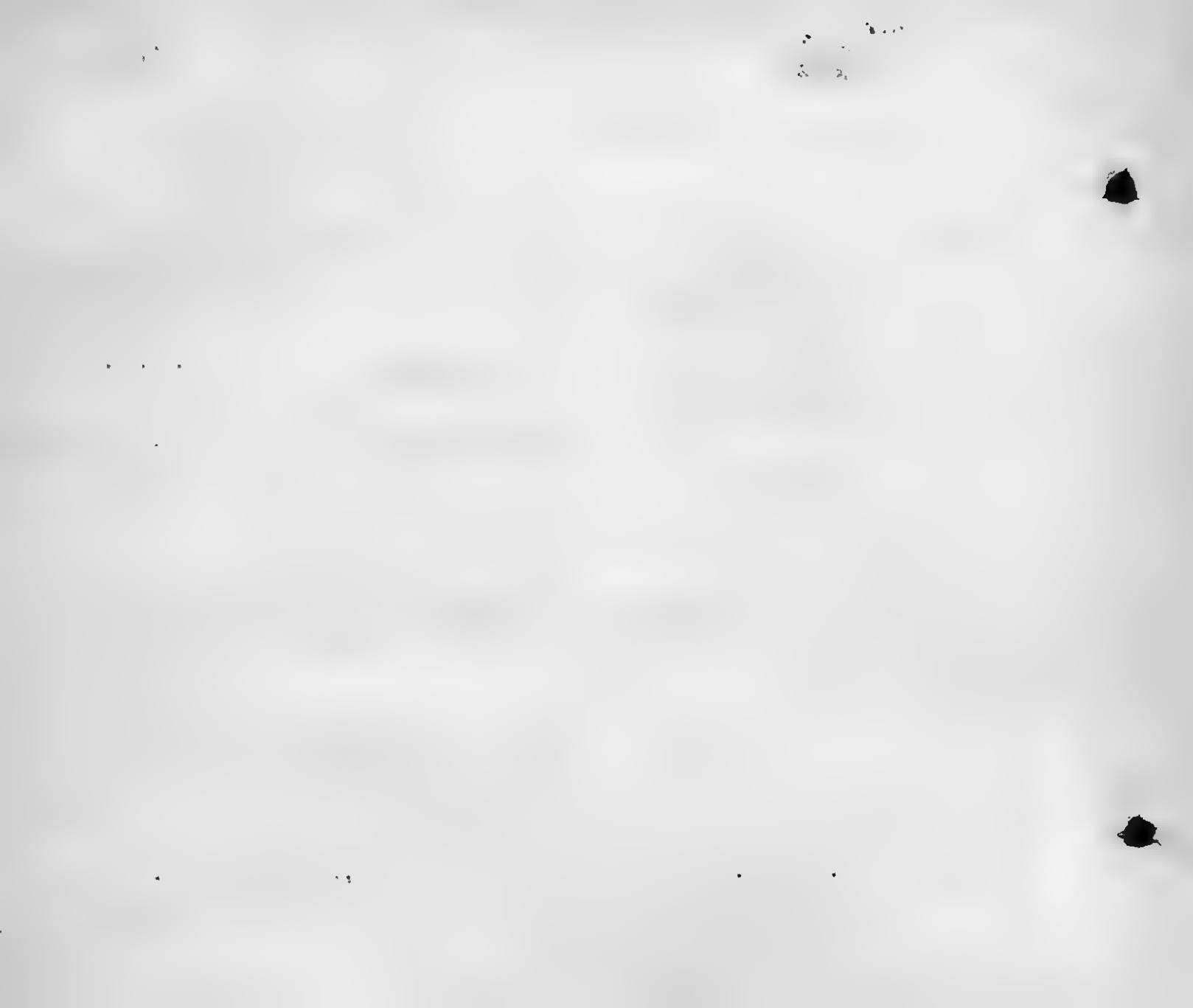
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2-1-62 20f. (City or town) 2-2-62 (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-1-62 to 2-2-62, 1962, that (I) (we) last saw the deceased alive on 2-1-62, and that death occurred at 7:30 PM, from the causes and on the date stated above

22a. SIGNATURE Ar T. Allen 22b. DATE SIGNED 2-3-62  
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐  
22c. PHYSICIAN'S NAME (Type) Dr. Aris T. Allen 22d. ADDRESS Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2-6-1962 23c. NAME OF CEMETERY OR CREMATORY Brewer Hall 23d. LOCATION (City, town or county) Annapolis (State) Md

24. FUNERAL DIRECTOR'S SIGNATURE William K. Reese ADDRESS Annapolis 25a. REC'D BY REGISTRAR 2-9-62 25b. REGISTRAR'S SIGNATURE John S. Hines





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01449

01434

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY in lb <u>30 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOMewood CONValescent</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q.A.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> d. STREET ADDRESS <u>Rt 1, Box 76</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ralph M. Carey</u>		4. DATE OF DEATH Month Day Year <u>Feb 13 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 13, 1880</u>	
9. AGE (In years last birthday) <u>81</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Business</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 011183</u>	
17. INFORMANT <u>Mrs. Mary Carey - Above</u>		Address <u>Below</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Myocardial Insufficiency</u> <u>Arteriosclerotic Heart Disease</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>3 yrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-5-58</u> , 19....., to <u>2-13-</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>2-10-</u> , 19 <u>62</u> and that death occurred at <u>1 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James R. Martin</u>		22b. DATE SIGNED <u>2-13-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		22d. ADDRESS <u>65 HAW ST. ANNAPOLIS, MD.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>2-15-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Baranco, Seaside Pk.</u>		25a. REC'D BY REGISTRAR <u>FEB 16 1962</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kruza</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01450 CERTIFICATE OF DEATH 01435											
1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNAPOLIS</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>121 Cathedral St.</u>					
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Marion</u> Last <u>CLARK</u>						4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1962</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>1</u> Day <u>1</u> Year <u>1906</u>		9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School teacher</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank M. Marshall</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth B. Clark</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>224637786</u>		17. INFORMANT <u>Arthur S. Kraus</u> Address <u>121 Cathedral St., Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420a1</u> DUE TO (b) <u>Coronary artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Rheumatoid Arthritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>D.O.A.</u> <u>3 mos.</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>00</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Annapolis</u>		(County) <u>Prince George's</u>		(State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1-9-62</u> 19 <u>62</u> to <u>2-26</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>2-23-62</u> and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank M. Shipley</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-27-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Frank M. SHIPLEY, M.D.</u>						22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-28-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>		23d. LOCATION (City, town or county) <u>Annapolis</u>		(State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>				25a. REC'D BY REGISTRAR <u>WAR</u> DATE <u>7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

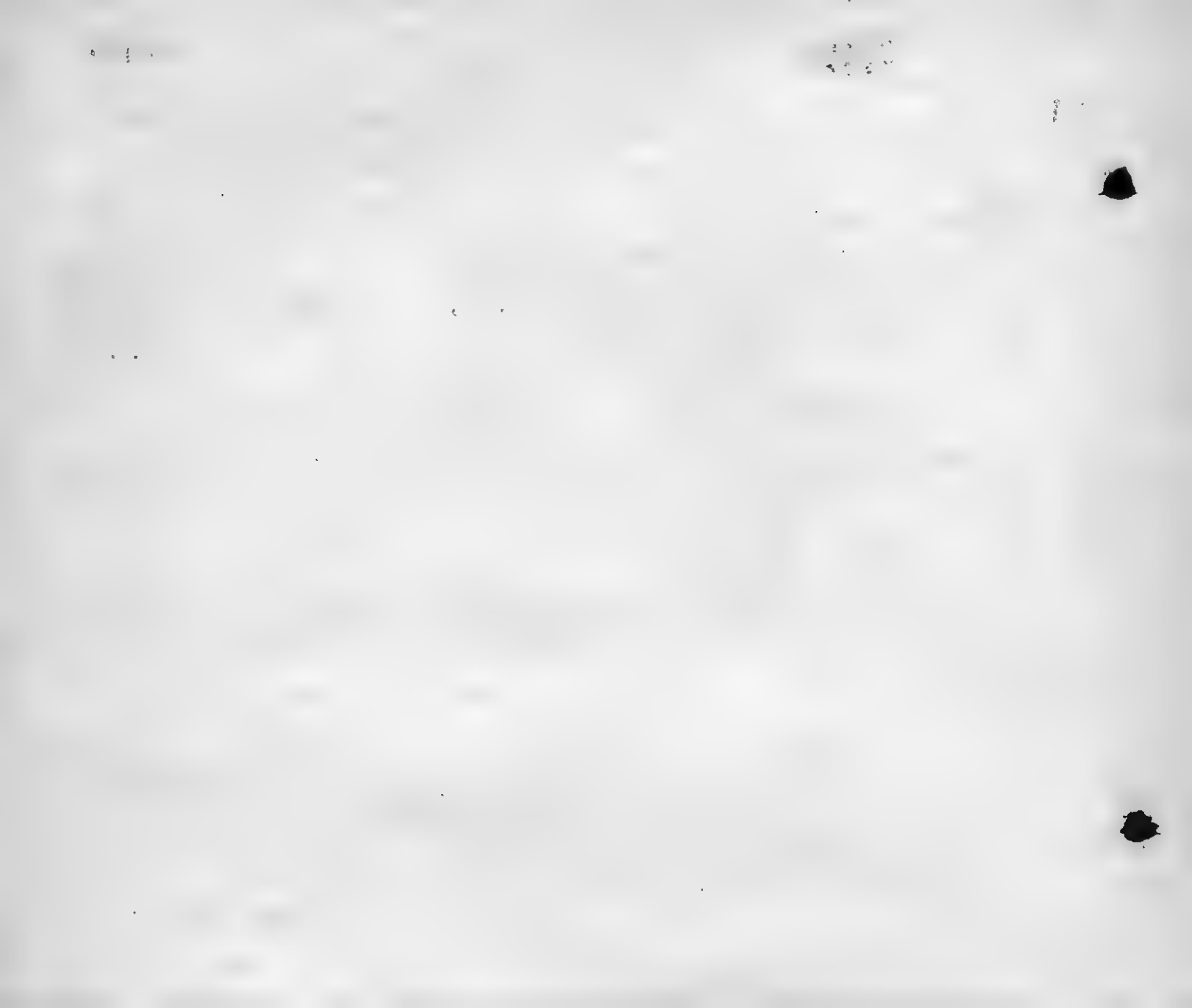
VR AIS (4)  
15M 7 61

01451

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01436

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 2 Acton Place	
3. NAME OF DECEASED (Type or print) William Albert CLARK		4. DATE OF DEATH February 13 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1890
9. AGE (in years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Drug Store	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Clark		14. MOTHER'S MAIDEN NAME Anna P. Lowman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Helen K. Clark	
17. INFORMANT Address (2)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. 33 IX DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (his/her) attended the deceased from 2-12-1962 to 2-13-1962, that (I) (he) last saw the deceased alive on 2-13-1962, and that death occurred at 5:30 AM, from the causes and on the date stated above. 22a. SIGNATURE Frank M. Shipley M.D. 22b. DATE SIGNED 2-13-62 22c. PHYSICIAN'S NAME (Type) FRANK M. SHIPLEY 22d. ADDRESS Annapolis Md 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2-15-1962 23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cont 23d. LOCATION (City, town or county) Annapolis (State) Md 24. FUNERAL DIRECTOR'S SIGNATURE John W. Vayler Sues 25a. REC'D BY REGISTRAR DATE FEB 16 '62 25b. REGISTRAR'S SIGNATURE Arthur E. Thomas	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

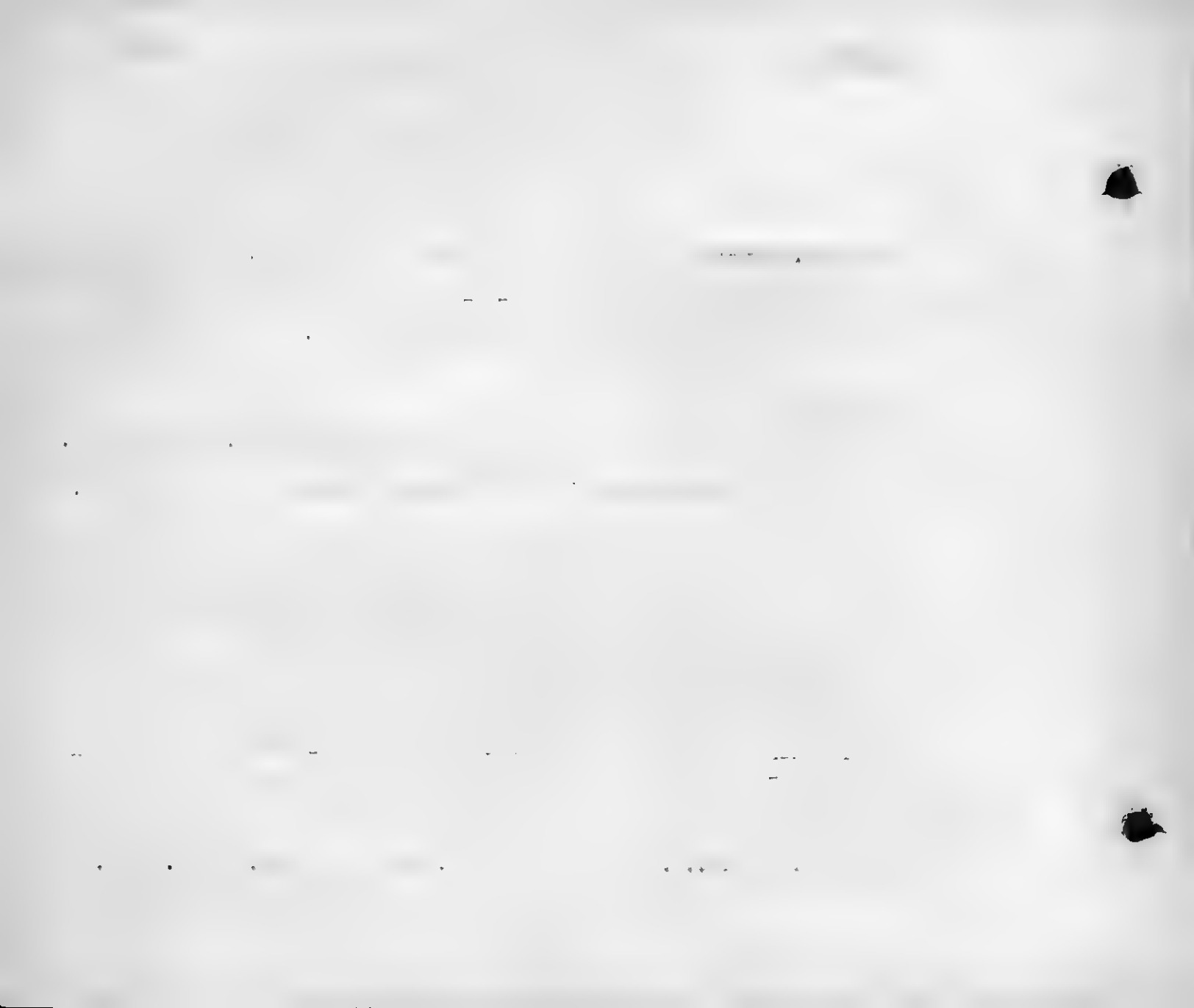
01452

CERTIFICATE OF DEATH

01437

Items 11 & 12 File 0308 3/9/62 mh

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN Tb <b>3 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>		d. STREET ADDRESS <b>53 Fleet Street</b>	
3. NAME OF DECEASED (Type or print) <b>Hattie T. Colbert Phelps Colbert</b>		4. DATE OF DEATH <b>February 24, 19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-16-1875</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11 BIRTHPLACE (State or foreign country) <b>Anne Arundel, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>Unknown/ USA</b>	
13. FATHER'S NAME <b>William Phelps</b>		14. MOTHER'S MAIDEN NAME <b>Sarah ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17 INFORMANT <b>Walter Colbert</b>		Address <b>53 Fleet St. Annapolis, Md.</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-8-1961</b> 12 to <b>2-24-1962</b> 19 that (I) (we) last saw the deceased alive on <b>2-17</b> 1962, and that death occurred at <b>7A</b> M, from the causes and on the date stated above			
22a SIGNATURE <b>James M. Pair</b>		22b DATE SIGNED <b>2-24-1962</b>	
22c PHYSICIAN'S NAME (Type) <b>James M. Pair, Md.</b>		22d ADDRESS <b>400 N. Carrollton Ave. Balto. 23, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>2-27-62</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		23d LOCATION (City, town or county) (State) <b>ANNAPOILIS - Md</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hakes III Maryland</b>		25a REC'D BY REGISTRAR <b>DATE MAR 2 '62</b>	
ADDRESS <b>annapolis</b>		25b REGISTRAR'S SIGNATURE <b>William E. Hakes</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Page 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01438

1. PLACE OF DEATH a. COUNTY <u>ALCO</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CUMBERSTONE</u>		c. LENGTH OF STAY IN MD <u>MD</u>	
3. NAME OF DECEASED (Type or print) <u>ALLEN</u>		First Middle Last <u>OWEN CUMBERSTONE</u>		4. DATE OF DEATH Month Day Year <u>FEB 7 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>May 23, 1894</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City & State, or foreign country) <u>LOTHIAN MD</u>	
13. FATHER'S NAME <u>JAMES WILLIAM CUMBERSTONE</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET WARD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>213-22-1842 Allen Owen Cumberstone Cumers Stone Md</u>		16. SOCIAL SECURITY NO. <u>213-22-1842</u>		17. INFORMANT <u>Address</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acc Cerebral Thrombosis</u> DUE TO <u>Antihypertensive C.V. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Fibillation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Early 8-1-1961</u> to <u>Feb 4, 1962</u> that (I) (we) last saw the deceased alive on <u>12-6-1961</u> and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Mannie Klawns</u> MD		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>MANIE F. KLAUANS, MD</u>	
22d. ADDRESS		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Feb 12 1962</u>		<u>Mt Zion Cemetery</u>	
23d. LOCATION (City, town or county)		(State)			
<u>Lothian Md</u>		<u>Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>T. Harcourt</u>		ADDRESS <u>Galesville Md</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 19 62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Colton S. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01454

CERTIFICATE OF DEATH

01439

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ANNE ARUNDEL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNE ARUNDEL GEN'L. HOSPITAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena (Magoth Beach)</u> d. STREET ADDRESS <u>Riverside Drive Apt. #5</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Muriel H. Emmons</u>		<b>4. DATE OF DEATH</b> <u>FEB 23 1962</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6 June 1906</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Whitehall, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Eugene Ford</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ada Mc Tilton</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>	
<b>17. INFORMATION</b> <u>Mr. Russell Emmons - Same old</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>TERMINAL BRONCHO-PNEUMONIA</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>BRONCHOGENIC CARCINOMA</u> (c) _____	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS.</u> <u>1 YEAR</u>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part I of item 1B.)	
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> _____ (County) _____ (State) _____
<b>21. I certify that (I) (this hospital) attended the deceased from <u>FEB 2</u>, 1962 to <u>FEB 22</u>, 1962, that (I) (we) last saw the deceased alive on <u>FEB 22</u>, 1962, and that death occurred at <u>6:15 AM</u>, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Arthur Lankford Jr.</u>		<b>22b. DATE SIGNED</b> <u>2/23/62</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>ARTHUR LANKFORD JR.</u>		<b>22d. ADDRESS</b> <u>2934 MOUNTAIN RD PASADENA, MD.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>27 Feb. 1962</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glenn Haven Cemetery</u>	<b>23d. LOCATION (City, town or county)</b> <u>Glenn Burnie - Md.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>R. F. Dingle</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Feb 28 '62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Evans</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01455

01440

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Annapolis</u>	
c. LENGTH OF STAY IN 1b <u>12 days</u>		d. STREET ADDRESS <u>Rt-4, Box-203 (Cape St. Claire)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Jessie</u> Middle <u>ERDMAN</u> Last <u>ERDMAN</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>4</u> Year <u>19 62</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 31, 1883</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Institution</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John W. Hayne</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Craig</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219 30 8000</u>	
17. INFORMANT <u>Mrs. Jessie Diggs</u>		Address <u>Same As #2</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral artery thrombosis</u> 352X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) DUE TO <u>  </u> (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertensive Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (1) <u>this hospital</u> attended the deceased from <u>Jan. 23, 1962</u> , to <u>Feb. 4, 1962</u> , that (1) <u>xx</u> last saw the deceased alive on <u>Feb. 4, 1962</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard N. Peeler</u> M.D.		22b. DATE SIGNED <u>2/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard N. Peeler, M.D.</u>		22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6th Feb. '62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard N. Peeler</u>		25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>  </u>		DATE <u>FEB 8 '62</u>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**01441**

**01456**

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>A.A.Co.</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL, ANNAPOLIS</b>				c. LENGTH OF STAY IN 1b <b>&gt;</b> <b>RURAL, ANNAPOLIS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Old Annapolis Blvd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>Ewing</b> Last <b>Ewing</b>				4. DATE OF DEATH Month <b>2</b> Day <b>2</b> Year <b>1962</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-23-1885</b>	9. AGE (In years lost birthday) <b>76</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>GEORGE EHATT</b>				14. MOTHER'S MAIDEN NAME <b>MARIA AUSTATT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>MRS. WALTER R. HARTKE #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> DUE TO <b>Arteriosclerotic Heart Disease</b> (b) <b>12000</b> DUE TO <b>12000</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 3, 1962</b> to <b>Feb 2, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 30, 1962</b> and that death occurred at <b>5:00 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>James R. Martin</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>JAMES R. MARTIN</b>		22d. ADDRESS <b>6 SHAW ST. ANNAPOLIS, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>2-3-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		23d. LOCATION (City, town, or county) <b>ANNAPOLIS</b> (State) <b>MD.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Saylor</b>		ADDRESS <b>Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>DATED 5 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Martin</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01457

## CERTIFICATE OF DEATH

01442

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ANNE ARUNDEL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> c. LENGTH OF STAY IN 1b <u>45 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A.A. GENERAL HOSPITAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> d. STREET ADDRESS <u>Arnold Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>John VERNON FAY</u>		<b>4. DATE OF DEATH</b> Month <u>2</u> - Day <u>6</u> - Year <u>1962</u>		<b>5. SEX</b> <u>Male</u>									
<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan 11, 1885</u>									
<b>9. AGE</b> (In years last birthday) <u>77</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>retired</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>CHICAGO, ILLINOIS</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>JOHN V. FAY</u>									
<b>14. MOTHER'S MAIDEN NAME</b> <u>IDA OCEA BYRON</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>212-14-2605</u>									
<b>17. IN ADDRESS</b> <u>605 S. DECKER AVE.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arterio cardiovascular Disease</u> (c), stating the underlying cause last. <u>Years.</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)											
<b>20c. TIME OF INJURY</b> Hour <u>a.m.</u> Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)									
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov. 1961</u> , to <u>Feb. 6, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan. 26, 1962</u> <b>and that death occurred at</b> <u>11 PM</u> , <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Faye W. Allen</u>		<b>22b. DATE SIGNED</b> <u>Feb 6, 1962</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Faye W. Allen</u>									
<b>22d. ADDRESS</b> <u>62 Cathedral St Annapolis, Md</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>											
<b>23b. DATE THEREOF</b> <u>2/9/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>OAK LAWN</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>BALTO. CO. MD.</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>George W. Hoffmann</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Feb 9 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>(Signature)</u>									



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM  
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01458

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01443

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>1 Monticello Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>ADDISON</b> Middle <b>J</b> Last <b>FINK</b>				4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 27, 1916</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail store</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		9. AGE (In years last birthday) <b>45</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>	
13. FATHER'S NAME <b>Frank J. Fink</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Tucker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO. <b>220 09 6527</b>			
17. INFORMANT <b>Mr Thomas J. Fink - Son - Same address # 2</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>Chronic Pulmonary Emphysema</b> <b>partial</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <b>partial</b>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>2/27/62</b>							
ACTUAL SIGNATURE <b>Howard G. Shaub</b> EXAMINER'S NAME (Type) <b>HOWARD G. SHAUB, M. D.</b> Address (Street, city, town, or county) <b>Annapolis, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 2, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>2/27/62</b>		24b. REGISTRAR'S SIGNATURE <b>William J. Hopper</b>	

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

01459

## CERTIFICATE OF DEATH

01444

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
c. LENGTH OF STAY IN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		5. AGE (In years last birthday)	
6. COLOR OR RACE		6. IF UNDER 1 YEAR	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. IF UNDER 24 HRS.	
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. MONTHS	
9. DATE OF BIRTH		9. DAYS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. BIRTHPLACE (County & State, or foreign country)	
10c. KIND OF BUSINESS OR INDUSTRY		10d. CITIZEN OF WHAT COUNTRY?	
11. FATHER'S NAME		11. MOTHER'S MAIDEN NAME	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		12. SOCIAL SECURITY NO.	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		13. INFORMANT	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Uremia with anasarca		13. ADDRESS	
572X DUE TO		13. INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		13. 5 days	
DUE TO		13. Unknown	
DUE TO		13. Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		13. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY		20d. INJURY OCCURRED	
20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.)		20f. (City or town)	
20g. (County)		20h. (State)	
21. I certify that (1) <del>deceased</del> attended the deceased from Feb. 8, 1962, to Feb. 14, 1962, that (1) <del>was</del> saw the deceased alive on Feb. 14, 1962, and that death occurred at 11:00 AM from the causes and on the date stated above		22a. SIGNATURE	
22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22f. BURIAL, CREMATION REMOVAL (Specify)		22g. DATE THEREOF	
22h. NAME OF CEMETERY OR CREMATORY		22i. LOCATION (City, town or county)	
22j. FUNERAL DIRECTOR'S SIGNATURE		22k. REGISTRAR'S SIGNATURE	
22l. REC'D BY REGISTRAR		22m. DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01460

## CERTIFICATE OF DEATH

01445

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Severna Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>1</u>	
<b>3. NAME OF</b> (Type or print) First <u>Gardner</u> Middle <u></u> Last <u></u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>3</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>February 3, 1962</u>
<b>9. AGE</b> (In years last birthday) <u>2</u> yrs. <u>10</u> months <u>10</u> days		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u></u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Annapolis, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Robert Gardner</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Barbara</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u></u>		<b>16. SOCIAL SECURITY NO.</b> <u></u>	
<b>17. INFORMANT</b> <u>Hospital records</u>		<b>Address</b> <u></u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature</u> 77ix DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>(5 months) wt 15-02</u> DUE TO (c) <u></u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u></u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u></u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
<b>20c. TIME OF INJURY</b> Hour <u>a.m.</u> Month, Day, Year <u>19</u>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u>	<b>20f. (City or town)</b> (County) (State) <u>Severna Park, Md.</u>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb. 3, 1962</u> <b>to</b> <u>Feb. 3, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2-3-1962</u> <b>and that death occurred at</b> <u>5:45 A.M.</u> <b>from the causes and on the date stated above,</b>			
<b>22a. SIGNATURE</b> <u>Francis I. Codd</u> M.D.		<b>22b. DATE SIGNED</b> <u>Feb 3, 1962</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. Francis I. Codd</u>		<b>22d. ADDRESS</b> <u>Severna Park, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Feb 5, 1962 Cedar Hill</u>	<b>23b. DATE THEREOF</b> <u>Feb 5, 1962</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore md</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Geo L. Schorsch</u>		<b>25a. REC'D BY REGISTRAR</b> <u>2101 Frederick Ave</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Robert S. Kraus</u>		<b>DATE</b> <u>FEB 6 '62</u>	

2. 7. 11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01461

01446

1. PLACE OF DEATH a. COUNTY <i>D. D.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>D. D.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harwood Md.</i>		c. LENGTH OF STAY in 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Samuel</i> Middle <i>Harner</i> Last		4. DATE OF DEATH Month <i>2</i> Day <i>3</i> Year <i>1962</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-7-1882</i>
9. AGE (In years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of serv. ce.)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Agnes Mock, Harwood Md.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic cardiovascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>14-22-1</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/17</i> 19 <i>61</i> , to <i>2/3</i> 19 <i>62</i> , that (I) (we) last saw the deceased alive on <i>1/31</i> 19 <i>62</i> and that death occurred at <i>2</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>S. B. Kussak M.D.</i>		22b. DATE SIGNED <i>2/5/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>S B Kussak</i>		22d. ADDRESS <i>Annapolis Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-7-1962</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese Jr. Annapolis Md</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 9 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>WRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Solley Road</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>Solley Road - Rt. 11 - Box 120</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS G. GOETZ</u>		4. DATE OF DEATH <u>February 23rd 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28th Sept. 1878</u>
9. AGE (In years, last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Green Castle, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(unknown) Goetz</u>		14. MOTHER'S MAIDEN NAME <u>(unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Evelyn Shawen</u>		Address <u>Pasadena, Md. Powhatan Beach Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> DUE TO (b) <u>arteriosclerotic heart disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 2, 1962</u> to <u>February 23, 1962</u> ; that (I) (we) last saw the deceased alive on <u>Feb. 21, 1962</u> , and that death occurred at <u>6 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>R. M. McLaughlin</u>		22b. DATE SIGNED <u>2/23/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>		22d. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>26th Feb. '62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Brooklyn, RFD, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. M. McLaughlin</u>		25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>L. K. Kious</u>		DATE <u>FEB 28 '62</u>	

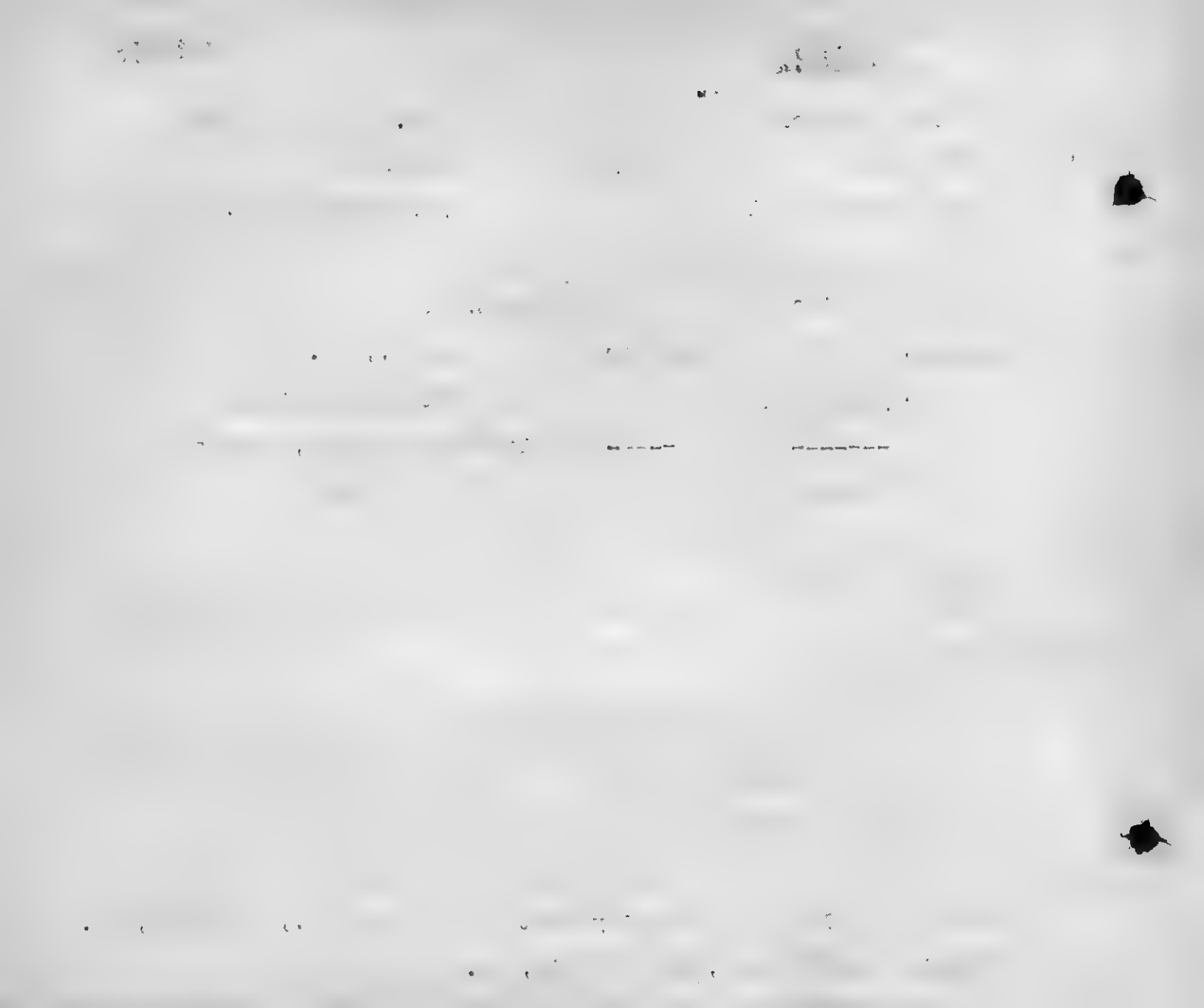


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**01463** **CERTIFICATE OF DEATH** **01448**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> c. LENGTH OF STAY IN Bldg. <b>89 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bayside Beach Drive</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> d. STREET ADDRESS <b>Bayside Beach Drive</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Harry</b> First Middle Last <b>Male</b> <b>White</b> <b>WIDOWED</b> <b>DIVORCED</b> <b>Farmer</b> <b>Harry Hancock</b>		<b>4. DATE OF DEATH</b> <b>Feb 14 19 62</b> <b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Sept. 8, 1872</b> <b>9. AGE</b> (In years last birthday) <b>89 yrs.</b> <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Own Farm</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>AA Co., Md.</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>USA</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b> <b>13. FATHER'S NAME</b> <b>Harry Hancock</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Matilda Wilkinson</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> <b>16. SOCIAL SECURITY NO.</b> <b>MISS</b> <b>17. INFORMANT</b> <b>Miss Matilda Cook, Same as 2</b> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4 2 0 0</b> <b>IMMEDIATE CAUSE (a)</b> <b>Congestive Heart Failure</b> <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <b>(c)</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>none</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>12 hrs.</b> <b>5 years.</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1949 to February 14, 1962 that (I) (we) last saw the deceased alive on February 13, 1962, and that death occurred at 11 A.M., from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <b>R.M. McLaughlin</b> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <b>2/15/62</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>R.M. McLaughlin</b> <b>22d. ADDRESS</b> <b>3708 Mountain Rd. Pasadena, Md.</b>			
<b>23a. BURIAL, CREMATION, 23b. DATE THEREOF</b> <b>Burial</b> <b>2/18/62</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Family Plot</b> <b>23d. LOCATION</b> (City, town or county) (State) <b>AA Co., Pasadena, Md.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Hopping and Kirkley, Glen Burnie, Md.</b> <b>ADDRESS</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE FEB 19 '62</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01464

01449

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE Md.</u> c. LENGTH OF STAY (In days) <u>7 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CROWNSVILLE STATE HOSPITAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> d. STREET ADDRESS <u>507 DOUGLAS ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>WILLIAM SRNEST HANDY</u>		<b>4. DATE OF DEATH</b> Month <u>FEBRUARY</u> Day <u>10</u> Year <u>1962</u>	
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>NEGRO</u>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>JULY 1, 1901</u>		<b>9. AGE</b> (In years last birthday) <u>60</u> yrs <u>60</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>UNKNOWN</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>WICOMICO CO., Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>UNITED STATES</u>	
<b>13. FATHER'S NAME</b> <u>UNKNOWN</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214107307</u>	
<b>17. INFORMANT</b> <u>STATISTICAL DATA FROM PATIENT'S HOSP. CHART</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxiation.</u> Conditions, if any, which gave rise to immediate cause (b) <u>Aspiration of regurgitated food.</u> (c) <u>Senile Psychosis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Chronic Brain Syndrome due to Cerebral Arteriosclerosis</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II. of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>9/9/1959</u> <b>to</b> <u>2/10/1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2/10/1962</u> <b>and that death occurred at</b> <u>10 PM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Lionel McHenry Mapp</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Lionel McHenry Mapp M.D.</u>		<b>22b. ADDRESS</b> <u>Crownsville State Hospital, Maryland.</u>	
<b>23a. BURIAL, CREMATION REMOVAL (Specify)</b> <u>burial</u> <b>23b. DATE THEREOF</b> <u>2-14-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Green Lane</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William Wright</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 16 62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>James Ann M.D.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02692

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> <sup>first</sup> <u>Harris</u> <sup>last</sup>		4. DATE OF DEATH <u>Feb. 5<sup>th</sup></u> <sup>Month</sup> <u>1962</u> <sup>Year</sup>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1883</u> <sup>79</sup> <sup>Yrs.</sup>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Prof.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Severn, A.A. Co., Md., U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No.</u>		16. SOCIAL SECURITY NO. <u>John Harris, Severn, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Generalized Arterio sclerosis</u> <u>1550.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Semibility</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>None</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 8<sup>th</sup> 1962</u> to <u>Feb 5<sup>th</sup> 1962</u> that (I) (we) last saw the deceased alive on <u>Feb. 4<sup>th</sup> 1962</u> and that death occurred at <u>9:00</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank E. Shipley</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D., Savage, Md.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/10/62</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Gambrells</u>		23d. LOCATION (City, town or county) (State) <u>Gambrells, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Eldon Wilson</u>		25a. REC'D BY REGISTRAR <u>1000</u> 25b. REGISTRAR'S SIGNATURE <u>Anthony P. Balthus</u>	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN IT <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Annapolis</u> d. STREET ADDRESS <u>Rt-2, Box-423</u>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Gus</u> Middle <u>HARRIS</u> Last <u>HARRIS</u> <b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>15</u> Year <u>1962</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Negro</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>December 17, 1898</u> <b>9. AGE</b> (In years last birthday) <u>63</u> yrs Months <u>63</u> Days <u>63</u> Hours <u>63</u> Min <u>63</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>TEAM</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FARMER</u> <b>11. BIRTHPLACE</b> (Country, state, or city) <u>Delaware</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		
<b>13. FATHER'S NAME</b> <u>SAMPSON HARRIS</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Nancy HARRIS</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO</b> <u>214-05-1616</u> <b>17. INFORMANT</b> <u>Lillie Harris - Annapolis, Md.</u> Address <u></u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> (b) <u>Essential hypertension</u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>331X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>Year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <u></u>		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u></u> e.m. <u></u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u>		<b>20f. (City or town)</b> (County) (State) <u></u>		
<b>21. I certify that (I) (doctor) attended the deceased from <u>Feb. 14, 1962</u> to <u>Feb. 15, 1962</u>, that (I) (do) saw the deceased alive on <u>Feb. 15, 1962</u>, and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.</b>				
<b>22a. SIGNATURE</b> <u>G. Church</u>		<b>22b. DATE SIGNED</b> <u>2/16/62</u>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Gerard Church</u>		<b>22d. ADDRESS</b> <u>121 Cathedral St., Annapolis, Md.</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>2-18-62</u>		
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Richards Cem.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>EASTON, Md.</u>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James E. Cashell, Easton, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 20 1962</u>		
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Smith</u>		<b>25c. DATE</b> <u></u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

tem 10 File 3-7-64

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01466 01451

1. PLACE OF DEATH  
a. COUNTY Anne Arundel County

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  
Found in the woods near Skidmore

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE Maryland b. COUNTY Anne Arundel

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  
Annapolis

d. STREET ADDRESS  
Route 2, Box 376

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)  
HTIDA MAE HARRIS

4. DATE OF DEATH  
February 23, 1962

5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH  
9-19-1935

9. AGE (In years last b. thday) 26 yrs. IF UNDER 1 YEAR: Months 26 Days 26 Hours 26 Min. 26

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
Maryland

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME  
Phillip Harris

14. MOTHER'S MARDEN NAME  
Etta Cromwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No 16. SOCIAL SECURITY NO. 1-280-376

17. INFORMANT  
Etta Cromwell R. 2 Box 376 Annapolis

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Epilepsy  
DUE TO 353.3  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 353.3 DUE TO (c) 353.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 353.3

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 19 p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

DEPUTY MEDICAL EXAMINER ☐

ACTUAL SIGNATURE Howard G. Shaub M.D.

EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D.

22a. BURIAL, CREMATION OR REMOVAL (Specify)  
Burial

22b. DATE THEREOF  
2-28-1962

22c. NAME OF CEMETERY OR CREMATORY  
Broadneck

22d. LOCATION (City, town, or country) (State)  
Annapolis, Md.

23. FUNERAL DIRECTOR  
Wm. Reese II

24a. REC'D BY REGISTRAR  
1 '62

24b. REGISTRAR'S SIGNATURE  
St. Margarets M.C.

DATE SIGNED  
2/24/62

VS. A15ME SM 9/60





01467

CERTIFICATE OF DEATH

01452

1. PLACE OF DEATH  
a. COUNTY Maryland  
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Annapolis  
c. LENGTH OF STAY IN 1b 5 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE Maryland  
b. COUNTY Anne Arundel  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie  
d. STREET ADDRESS 500 Crain Highway  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Anne Arundel  
First Virginia Middle HEMSTETTER Last HEMSTETTER

4. DATE OF DEATH February 9 1962  
Month February Day 9 Year 1962

5. SEX Female  
6. COLOR OR RACE White  
7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH March 4, 1918  
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) 43 yrs.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife  
10b. KIND OF BUSINESS OR INDUSTRY Own Home  
11. BIRTHPLACE (County & State, or foreign country) Delaware  
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Walter R. Neall  
14. MOTHER'S MAIDEN NAME Grace McKinley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no  
16. SOCIAL SECURITY NO. 212 - 20 - 7188  
17. INFORMANT Edward Hemstetter, same as 2  
Address

18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia  
2x DUE TO Dr. Cerebral thrombosis  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO Generalized arteriosclerosis  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, chronic pyelonephritis, myocardial hypertrophy

19. INTERVAL BETWEEN ONSET AND DEATH 3 days 1 week  
years

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  
20d. INJURY OCCURRED While ☐ Not While ☐ at work at work  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)

21. I certify that (I) (the undersigned) attended the deceased from Feb. 4, 1962 to Feb. 9, 1962, that (I) (we) last saw the deceased alive on Feb. 9, 1962, and that death occurred at 2:40 PM from the causes and on the date stated above.

22a. SIGNATURE G. Church  
22b. DATE SIGNED Feb. 13 '62  
22c. PHYSICIAN'S NAME (Type) Gerard Church, M.D.  
22d. ADDRESS 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  
23b. DATE THEREOF 2/12/62  
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial  
23d. LOCATION (City, town or county) (State) Glen Burnie, Md.

24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley  
25a. REC'D BY REGISTRAR Feb 13 '62  
25b. REGISTRAR'S SIGNATURE William S. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01453

01468

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN TB <b>16 months</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Margaret</b>		d. STREET ADDRESS <b>Rt. 4 Box 90</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>W. Henson</b> Last <b></b>		4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-10-1880</b>
9. AGE lost <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Not known</b>	
11. BIRTHPLA <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Henson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Flewood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Echard, D.P.W. A.A.Co.</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> <b>434.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic cardiac decompensation</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes</b> <b>? yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic degenerative arthritis. Chronic cystitis.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-26-1960</b> to <b>2-21-1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 17, 1962</b> , and that death occurred at <b>8AM</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>James M. Pair</b>		22b. DATE SIGNED <b>2-22-1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>		22d. ADDRESS <b>400 N. Carrollton Avenue Balto. 23 Md.</b>	
23. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-26-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Broadneck</b>		23d. LOCATION (City, town, or county) (State) <b>St. Margaret, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. - Anna Md.</b>		25. REC'D BY REGISTRAR DATE <b>FEB 23 1962</b>	
ADDRESS <b></b>		25b. REGISTRAR'S SIGNATURE <b></b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01469						01454					
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1010 E. Eager Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Calaphas First Middle Calaphas Hines 4. DATE OF DEATH 2 20 19 62						5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sep. 8. DATE OF BIRTH November 20, 1915 9. AGE (In years last birthday) 46 IF UNDER 1 YEAR: Months Days Hours Min 2 20 19 62					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur 10b. KIND OF BUSINESS OR INDUSTRY ----- 11. BIRTHPLACE (County & State, or foreign country) Georgia 12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Rance Hines 14. MOTHER'S MAIDEN NAME Julia											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes ? 16. SOCIAL SECURITY NO. 160-16-9223 17. INFORMANT Hospital Records Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest due to status Epilepticus DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last, DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ----- 20c. TIME OF INJURY Month, Day, Year 2/16 1962 Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 2/16 1962, to 2/21 1962, that (I) (we) last saw the deceased alive on 2/21 1962, and that death occurred at 9:35 A.M. from the causes and on the date stated above.											
22a. SIGNATURE 22b. DATE 2/21/62 22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D. 22d. ADDRESS Crownsville State Hospital, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/26/62 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem. 23d. LOCATION (City, town or county) (State) Brooklyn Md.											
24. FUNERAL DIRECTOR'S SIGNATURE C. O. Wilson ADDRESS 1000 Brentley Ave. 25a. REC'D BY REGISTRAR DATE FEB 26 '62 25b. REGISTRAR'S SIGNATURE William L. Frazier											



TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Al. A.</u> <u>Crownsville</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Al. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt 1 Bot 114</u>		d. STREET ADDRESS <u>Rt 1 Bot 114</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>James</u>		4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-8-1900</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MARDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-42708</u>	
17. INFORMANT <u>Blake Green, Rt 1 Crownsville, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lubricant Toxic.</u> DUE TO <u>CO 8 1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/22/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-28-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Waterbury, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		24. REC'D BY REGISTRAR <u>Anna M. D.</u>	
25. REGISTRAR'S SIGNATURE <u>Anna M. D.</u>		DATE <u>1 62</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN b <b>22 years</b> <b>4 mos 6 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>?</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Dennis</b>		<b>4. DATE OF DEATH</b> Month <b>2/</b> Day <b>11/</b> Year <b>1962</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1874</b>
<b>9. AGE</b> (In years last birthday) <b>87 yrs.</b>		<b>10. BIRTHPLACE</b> (County & State or foreign country) <b>Unknown</b>	
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Unknown</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		<b>16. SOCIAL SECURITY NO</b> <b>Unknown</b>	
<b>17. INFORMANT</b> <b>Hospital Records</b>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration &amp; Inanition</b>			
Conditions, if any, which gave rise to immediate cause (b) <b>Anorexia</b>			
(c) <b>Senility</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Chronic Brain Syndrome due to Cerebral and Generalized Arteriosclerosis</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <b>-----</b>	
<b>20c. TIME OF INJURY</b> Hour a.m. <b>19</b> p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> at work <input type="checkbox"/> While <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		<b>20f. (City or town)</b> (County) (State) <b>10/5</b> <b>1939</b> <b>2/11</b> <b>1962</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>10/5</b> <b>1939</b> <b>2/11</b> <b>1962</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>2/11</b> <b>1962</b> , <b>and that death occurred at</b> <b>11:30 p.m.</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>L. Benedict, M. D.</b>		<b>22b. DATE SIGNED</b> <b>2/13/62</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>L. Benedict, M. D.</b>		<b>22d. ADDRESS</b> <b>Crownsville State Hospital, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>		<b>23b. DATE THEREOF</b> <b>2/20/62</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>University of Med. Sch. Balt.</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Reese II</b>		<b>25a. REC'D BY REGISTRAR</b> <b>2/23/62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01457

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian, MD</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian - MD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Thomas</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>1962</u>			
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-1894</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>HARWOOD MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Tudor Jones.</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Weir Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>214-40-2850</u>		17. INFORMANT Address <u>Mrs Wm. Thomas Jones Lothian, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> 443 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-4-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB 6, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT ZION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Lothian MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>T A Hardesty + Son</u>				ADDRESS <u>Galesville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. Shurt. L. Farmer</u>			

MEDICAL CERTIFICATION

2



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01473

## CERTIFICATE OF DEATH

01458

Items 11 & 12 Film 6300 3/1/62 iwk

1. PLACE OF DEATH a. COUNTY <u>AA.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>211 10th Ave</u>		e. STREET ADDRESS <u>211 10th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Anten</u> Middle <u>J.</u> Last <u>Malinoda</u>		4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-91</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
11. BIRTHPLACE (County & State, or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Czech</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>FAMILY - JANE</u>		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>apoptation pneumonia</u> DUE TO (b) <u>cerebral thrombosis</u> DUE TO (c) <u>encephalomalacia</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>2 x 2</u> <u>3 weeks</u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year _____ 19 _____	24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	26. (City or town) _____ (County) _____ (State) _____
27. I certify that (I) (this hospital) attended the deceased from <u>March 1959</u> to <u>Feb. 18, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb. 17, 1962</u> and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.			
28. SIGNATURE <u>H. G. Summers</u>		29. DATE SIGNED <u>Feb. 18, 1962</u>	
30. PHYSICIAN'S NAME (Type) <u>H. G. Summers</u>		31. ADDRESS <u>211 10th Ave</u>	
32. BURIAL, CREMATION, REMOVAL (Specify)	33. DATE THEREOF <u>2-22-62</u>	34. NAME OF CEMETERY OR CREMATORY <u>Green Acre</u>	35. LOCATION (City, town or county) (State) <u>Baltimore</u>
36. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Lacey</u>		37. ADDRESS <u>130 E. Fort Ave.</u>	
38. REC'D BY REGISTRAR <u>Feb 20 '62</u>		39. REGISTRAR'S SIGNATURE <u>Caroline L. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERARY DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01474

01459

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY in lb <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>814 Boucher Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Deale</b> First <b>IV</b> Middle <b>LEATHERBURY</b> Last <b>February 14 1962</b>		4. DATE OF DEATH	
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 5, 1901</b> 9. AGE (In years last birthday) <b>60</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>City Garage, Annapolis</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Frank O</b> 14. MOTHER'S MAIDEN NAME <b>Sara J Windsor</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WWII</b> 16. SOCIAL SECURITY NO. <b>714079093</b> 17. INFORMANT <b>Mrs Jessie Leitch Davidson</b> Address <b>1401</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> (b) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Interval between onset and death</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour <b>10</b> a.m. <b>10</b> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>12-10-1960</b> to <b>2-6-1962</b> what (I) (we) last saw the deceased alive on <b>2-6-1962</b> and that death occurred at <b>4:30 PM</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>James R. Martin</b> 22c. PHYSICIAN'S NAME (Type) <b>James R. MARTIN, M.D.</b>		22b. DATE SIGNED <b>2-15-62</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>6 Shaw St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>2-16-62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Nat'l</b> 23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Bea of Hardy</b> ADDRESS <b>Salisbury</b> 25a. REC'D BY REGISTRAR <b>FEB 19 1962</b> 25b. REGISTRAR'S SIGNATURE <b>W. S. Harris</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01475											
01460											
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN b. <b>10 years 4 mos. 26 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b> d. STREET ADDRESS <b>?</b>					
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>Lee</b> Last <b>Lee</b>						4. DATE OF DEATH Month <b>2</b> Day <b>15</b> Year <b>19 62</b>					
5. SEX <b>Male</b>						6. COLOR OR RACE <b>Negro</b>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <b>December 23, 1938</b>					
9. AGE (In years last birthday) <b>23</b> yrs.						10. IF UNDER 1 YEAR Months <b>23</b> Days <b>15</b> Hours <b>19</b> Min. <b>62</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>					
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>William Lee</b>						14. MOTHER'S MAIDEN NAME <b>Alice Marshall</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>						16. SOCIAL SECURITY NO. <b>577-26-0786</b>					
17. INFORMANT <b>Hospital Records</b>						Address <b>-----</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tuberculosis Meningitis</b> DUE TO <b>015X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Tuberculosis Lymphadenitis</b> DUE TO (c) <b>-----</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <b>Pulmonary Embolism, Terminal</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>											
21. I certify that (I) (this hospital) attended the deceased from <b>9/14</b> to <b>2/15</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>2/15</b> , 19 <b>62</b> and that death occurred at <b>1:30 p.m.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Lionel McHenry Mapp, M.D.</b>											
22b. DATE SIGNED <b>2/15/62</b>											
22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M.D.</b>											
22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Feb. 19/62 St. Thomas</b>											
23b. DATE THEREOF <b>Feb. 19/62</b>											
23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas</b>											
23d. LOCATION (City, town or county) (State) <b>Aguasco Md</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>George &amp; Helen Aguasco, Md</b>											
25a. REC'D BY REGISTRAR <b>George &amp; Helen Aguasco, Md</b>											
25b. REGISTRAR'S SIGNATURE <b>George &amp; Helen Aguasco, Md</b>											
DATE <b>FEB 21 '62</b>											



01476

CERTIFICATE OF DEATH

02704

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riva</u> d. STREET ADDRESS <u>Danahonville</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>Baby</u> First Middle Last <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Negro</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>2-22-62  <b>9. AGE</b> (In years last birthday) <u>2</u> <b>IF UNDER 1 YEAR</b> <u>2</u> <b>IF UNDER 24 HRS.</b> <u>24</u>                  Months Days Hours Min.             </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			<b>11. BIRTHPLACE</b> (County & State, or foreign country)		
<b>13. FATHER'S NAME</b> <u>William H. Lowe</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)			<b>14. MOTHER'S MAIDEN NAME</b> <u>Helen Blake</u> <b>16. SOCIAL SECURITY NO.</b> <u>William H. Lowe Davidsonville</u> <b>17. INFORMANT</b> <u>William H. Lowe Davidsonville</u> Address		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Respiratory distress syndrome</u> 175.5 DUE TO <u>Probable hyaline membrane disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Prematurity</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH <u>36 hr</u> <u>36 hr</u> <u>36 hr</u>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>22 Feb</u> , 19 <u>62</u> , to <u>24 Feb</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>23 Feb</u> , 19 <u>62</u> , and that death occurred at <u>7:45 A</u> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>James I. Hudson</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>James I. Hudson, M.D.</u>			<b>22b. DATE SIGNED</b> <u>24 Feb 62</u> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>Edgewater, Maryland</u>		
<b>23a. BURIAL, CREMATION REMOVAL</b> (Spec by) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>3-3-1962</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Brewer Hill</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Annapolis Md.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>William Keese</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u> <b>DATE</b> <u>MAR 9 '62</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2-002977



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01477  
CERTIFICATE OF DEATH Item 8 film G307jac 01461

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
c. LENGTH OF STAY in institution 27 days and 1 month		d. STREET ADDRESS Melrose Str.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carlton P. Lumpkins (Lumkins)		4. DATE OF DEATH Month 2 Day 11 Year 19 62	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/1894/ 1895
9. AGE (In years last birthday) 65 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (County & State, or foreign country) Howard Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lumkins		14. MOTHER'S MAIDEN NAME Annie Dorsey Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 17. INFORMANT 217050311 Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adynamic ileus DUE TO Conditions, if any, which gave rise to immediate cause (b) Early peritonitis (c) DUE TO (e), stating the underlying cause last. Regional ileitis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/15, 1961, to 2/11, 1962, that (I) (we) last saw the deceased alive on 2/11, 1962, and that death occurred 12:30 pm from the causes and on the date stated above.			
22a. SIGNATURE Carl B. Schleifer		22b. DATE SIGNED 12 FEB 62	
22c. PHYSICIAN'S NAME (Type) CARL B. SCHLEIFER M.D.		22d. ADDRESS 363 DEWEY DR ANNAPOLIS MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1/16/62		23b. DATE THEREOF 1/16/62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]		25a. REC'D BY REGISTRAR DATE FEB 13 '62	
25b. REGISTRAR'S SIGNATURE [Signature]			



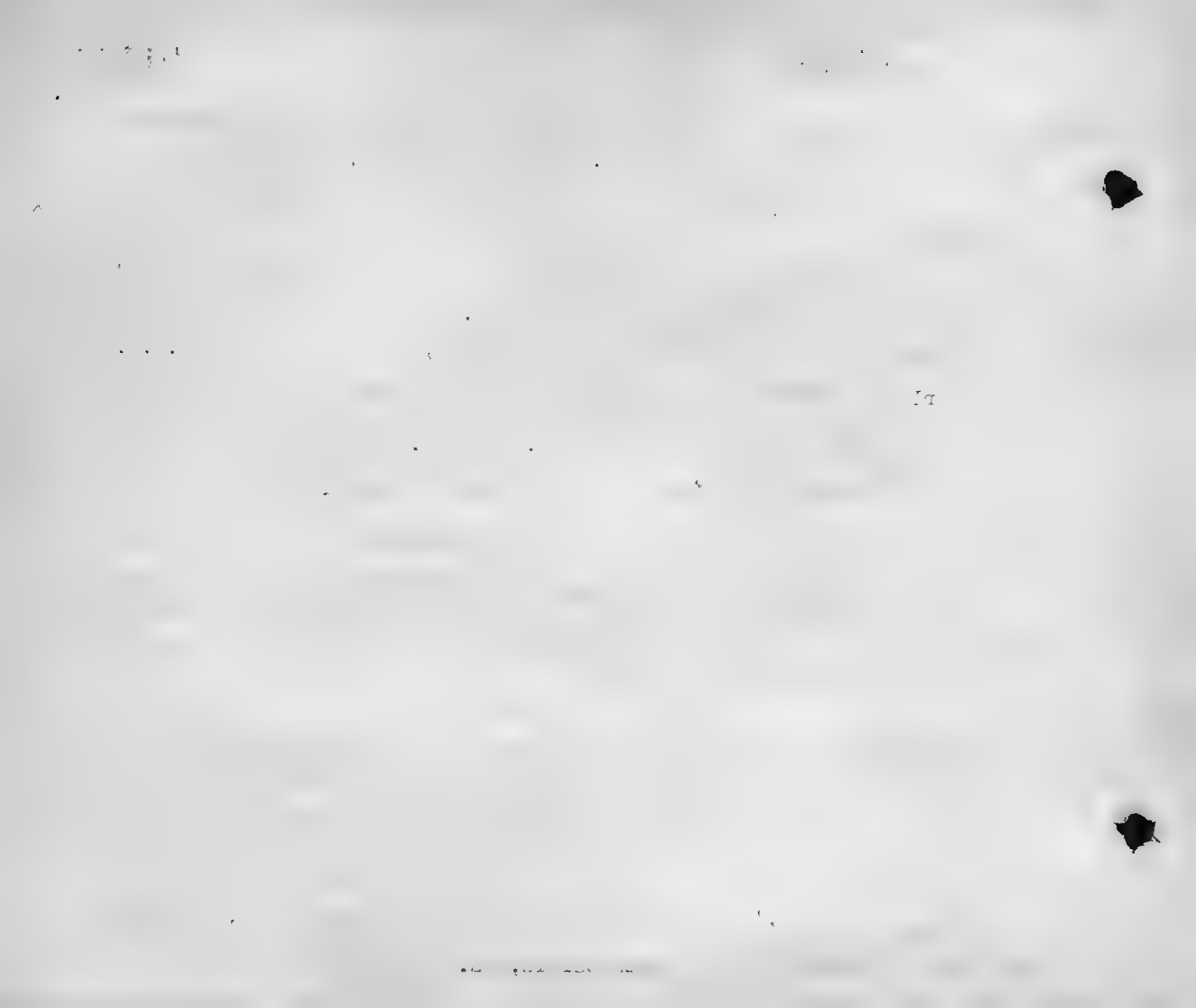
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01478

01462

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN It <u>2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville, (Elvaton)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Elvaton Road (Elvaton)</u>		d. STREET ADDRESS <u>Elvaton Road - Box #182</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>MACHIA</u> Last <u>MACHIA</u>		4. DATE OF DEATH Month <u>February</u> Day <u>13th</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14th Dec. 1900</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Elmore, Vermont</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Wheeler</u>		14. MOTHER'S MAIDEN NAME <u>Clara Emerson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Orrin N. Machia</u> Address <u>Same As #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 42 a. } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Passive Congestion of Heart</u> (c) <u>Hypertension, ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>months</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 49. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> ..., 1962 to <u>2/13</u> ..., 1962; That (I) (we) last saw the deceased alive on <u>2/10</u> ..., 1962, and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Ernest A. Leipold</u>		22b. DATE SIGNED <u>2/13/62</u>			
22c. PHYSICIAN'S NAME (Type) <u></u>		22d. ADDRESS <u>425 S. Ritchie Hwy, Glen Burnie, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>17th Feb. '62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town or county)	(State) <u>Northfield, Vermont</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 15 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Ernest A. Leipold</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.

VR A15 (4)  
15M 7-61

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01479  
CERTIFICATE OF DEATH  
02708

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 1 mo. 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1806 E. Fayette Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lawrence First Middle Last Lawrence Martin		4. DATE OF DEATH Month Day Year 2 16 1962	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1905
9. AGE (in years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Dementia due to Encephalitis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/11 1962, to 2/16 1962, that (I) (we) last saw the deceased alive on 2/16 1962, and that death occurred at 7:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Hildegard Heard Reissman, M.D. 22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M.D.		22b. DATE SIGNED 2/16/62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3-7-62		23b. DATE THEREOF 3-7-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore, Md.		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Giesse, Jr. - Annapolis, Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE MAR 8 '62	

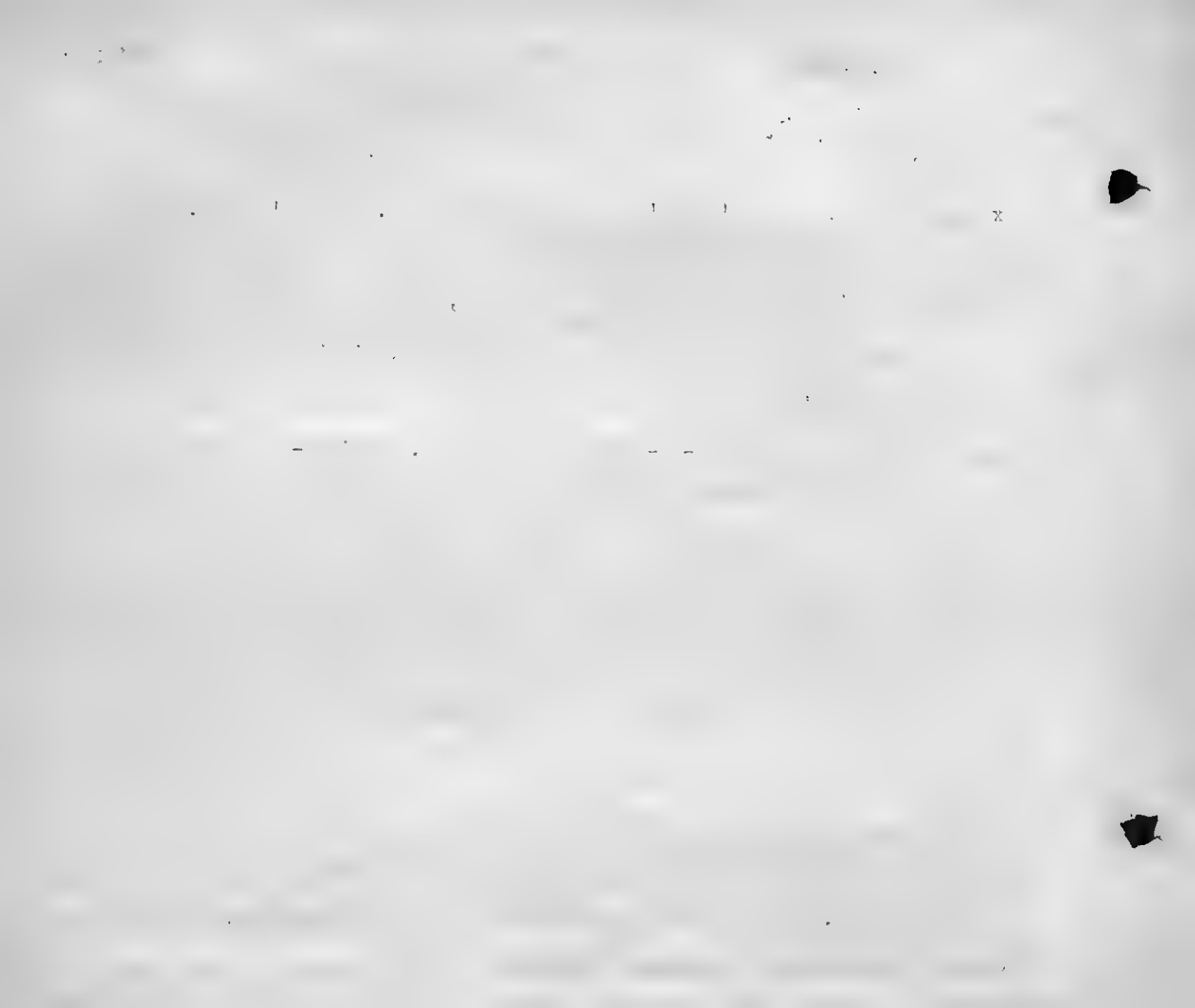


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01480 CERTIFICATE OF DEATH 01463

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>* Colonial Ave. Keeney's Apt's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>Colonial Ave. Keeney's Apts.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LILLIAN</b> Middle <b>McDONALD</b> Last <b>MORRISON</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>25</b> Year <b>1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 5, 1897</b>	
9. AGE (In years last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months <b>64</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Winchester, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Stephen Dandridge</b>		14. MOTHER'S MAIDEN NAME <b>Sidney Jane Kerns</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>219-30-5338</b>	
17. INFORMANT <b>Mr Charles W. Morrison- Husband - same as # 2</b>		Address <b>same as # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic cancer of liver</b> 156-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>primary site?</b> (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Acute</b> INTERVAL BETWEEN ONSET AND DEATH <b>5+ mo</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-3</b> 19 <b>62</b> to <b>2-25</b> 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>2-23-1962</b> , and that death occurred at <b>1:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank Shipley</b>		22b. DATE SIGNED <b>2-26-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frank Shipley MD</b>		22d. ADDRESS <b>Annapolis, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 28, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Martinsburg, West Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		24. ADDRESS <b>Annapolis, Maryland</b>	
25a. REC'D BY REGISTRAR <b>FEB 27 1962</b>		25b. REGISTRAR'S SIGNATURE <b>Colin S. Thomas</b>	



CERTIFICATE OF DEATH

Reg. Dist. No.

01465

01481

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port George G. Meade</b>		c. LENGTH OF STAY 'N 1b <b>4 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kimbrough Army Hospital</b>		d. STREET ADDRESS <b>909 Park Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>MICHAEL</b> Middle <b>J</b> Last <b>POHLMAN</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>31 May 61</b>
9. AGE (In years lost birthday) yrs <b>1</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>12</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Pohlman</b>		14. MOTHER'S MAIDEN NAME <b>Joyce Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Father</b>		Address <b>909 Park Ave Laurel, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration, severe</b> DUE TO (b) <b>Viral gastroenteritis</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9:45 AM</b> to <b>9:45 PM</b> and that death occurred at <b>9:45 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Morton Kane</b>		ADDRESS (Street, city or town, state) <b>Kimrough Army Hospital, Port George G. Meade, Md.</b>	
PHYSICIAN'S NAME (Type) <b>MORTON C. KANE, Capt., M.C.</b>		DATE SIGNED <b>14 Feb 62</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/14/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Dayton Ohio</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James G. Kane</b>		24a. READ BY REGISTRAR <b>DATE FEB 19 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>James G. Kane</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and page 2, and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



41  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01482  
CERTIFICATE OF DEATH  
01466

1. PLACE OF DEATH a. COUNTY <u>Anne Arundale</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MD.</u>	
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>Brethensville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
c. LENGTH OF STAY in <u>1 yr - 4 months</u>		d. STREET ADDRESS <u>1638 LAFAYETTE AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>Lizzie</u> Middle <u>Price</u> Last <u>Price</u>		4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1962</u>	
5. SEX <u>FM.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-6-93</u>
9. AGE (in years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Va -</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Day</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>421</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (a), stating the underlying cause last. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS spec. c. generalized arteriosclerosis &amp; Parkinson's Disease</u>			
19. INTERVAL BETWEEN ONSET AND DEATH <u>One day.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!) <u>  </u>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/1/60</u> 19 <u>  </u> to <u>2/24/62</u> 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>2/24/62</u> 19 <u>  </u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict M.D.</u>		22b. DATE SIGNED <u>2/25/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>		22d. ADDRESS <u>CROWNDSVILLE STATE HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 1, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cem.</u>		23d. LOCATION (City, town, county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Waller</u>		25a. REC'D BY REGISTRAR <u>  </u>	
25b. REGISTRAR'S SIGNATURE <u>Robert R. Waller</u>		25c. DATE <u>FEB 28 '62</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01483

01467

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>17 Cathedral St</u>		d. STREET ADDRESS <u>17 Cathedral St</u>	
3. NAME OF DECEASED (Type or print) <u>Leslie A. Guigley</u>		4. DATE OF DEATH <u>2 - 11 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 9 - 1892</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>11</u> Hours <u>19</u> Min. <u>62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>New York City</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>		13. FATHER'S NAME <u>Leslie Ward Carle</u>	
14. MOTHER'S MAIDEN NAME <u>Katie Leavitt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>G. Craig Carle</u> Address <u>Nyack N. Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Metastases</u> DUE TO (b) <u>Vaginal Sarcoma</u> DUE TO (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 - 2 yrs.</u> <u>1 yr.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>-</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>-</u> p. m. <u>-</u> 19 <u>62</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>2 - 11 1962</u> that (I) (we) last saw the deceased alive on <u>2 - 10 1962</u> and that death occurred at <u>-</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Shipley</u> M.D.		22b. DATE SIGNED <u>2 - 11 - 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK M. SHIPLEY</u>		22d. ADDRESS <u>Annapolis, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 14 - 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cent</u>	23d. LOCATION (City, town or county) (State) <u>Annapolis Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md.</u>		25a. REC'D BY REGISTRAR <u>ED 13 '62</u> DATE	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01484 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01468

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
c. LENGTH OF STAY IN 1b <u>Few instants</u>		d. STREET ADDRESS <u>14 Thomas Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pamela Gay Redmond</u>		4. DATE OF DEATH <u>February 3rd, 1962</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>2/28/54</u>	
9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Schoolgirl Elem. school</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Memorial Hosp. Riverdale, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis S. Redmond</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Louis Wampler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Louis S. Redmond (father)</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Fracture of skull, Fracture of pelvis.</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>  </u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Automobile in which she was riding slid and turned on the side.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year <u>1.20 P.M. 2/3/62</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <u>New Cut Road</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Severn</u>		20f. (City or town) <u>A.A.</u> (County) <u>Md.</u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/6/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		22d. LOCATION (City, town, or country) <u>Darby Maryland</u>	
23. FUNERAL DIRECTOR <u>W. H. Randall, Laurel Md.</u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>C. W. S. K...</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05375

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>116</b> c. LENGTH OF STAY IN 1b <b>116</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if inst. ful on. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>116 Conduit Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George W. Reid</b>		4. DATE OF DEATH <b>February 13 19 62</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 4, 1962</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>2 mos.</b>
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Allen Hoch Reid</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Kirwan Weltin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema and intra-alveolar hemorrhages</b> <b>773.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.)	
20c. TIME OF INJURY Month, Day, Year: _____ Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breiteneker, M.D.</b> EXAMINER'S NAME (Type)		DATE SIGNED <b>February 14, 1962</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATED</b>		22b. DATE THEREOF <b>5-29-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>City Morgue</b>		22d. LOCATION (City, town, or country) (State) <b>Balto. Md</b>	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR <b>DATE MAY 31 '62</b>	
		24b. REGISTRAR'S SIGNATURE <b>C. Thos. S. H. H.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01485  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>12 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2446 Cherry Hill Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eugene</b> Middle <b>Robinson</b> Last <b>Robinson</b>		4. DATE OF DEATH Month <b>2</b> Day <b>21</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1913</b>
9. AGE (In years last birthday) <b>48</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>21</b> IF UNDER 24 HRS. Hours <b>19</b> Min. <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Henry Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Bertha ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 1942-1944</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>paralytic ileus</b> DUE TO (b) <b>spiral cell tumor metastatic</b> DUE TO (c) <b>ca of prostate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION (EN IN PART I a) <b>chronic brain syndrome associated E CNS syphilis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>021X</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 16) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>-----</b> 19 <b>-----</b> p.m. <b>-----</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b> (County) <b>-----</b> (State) <b>-----</b>	
21. I certify that (I) (this hospital) attended the deceased from... <b>2/9</b> ... <b>19 62</b> to... <b>2/21</b> ... <b>19 62</b> , that (I) (we) last saw the deceased alive on... <b>2/21</b> ... <b>19 62</b> , and that death occurred about... <b>2/21</b> ... <b>19 62</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lionel McHenry Mapp</b>		22b. DATE <b>2/21/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/26/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Unit-Caberny</b>		23d. LOCATION (City, town or county) <b>Baltimore</b> (State) <b>Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>CHAS. RICE - 661 W. BARRE ST.</b>		25a. REC'D BY REGISTRAR <b>2/23/62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE

01486

CERTIFICATE OF DEATH

01470

M

I

1. PLACE OF DEATH a. COUNTY <u>Haric Annapolis</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2014-05-28</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>17</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>XSIDADYSIDE</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ARCHIE HARRISON ROGERS</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1908</u> 9. AGE (In years last birthday) <u>53</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTENDANT</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Service Station</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Sidyside ALA MD USA</u> 12. CITIZEN OF WHAT COUNTRY?		4. DATE OF DEATH <u>2</u> Month <u>M</u> Day <u>19</u> Year <u>62</u> 13. FATHER'S NAME <u>HARRISON H. ROGERS</u> 14. MOTHER'S MAIDEN NAME <u>ANNIE M. HALL</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>214-05-284</u> 17. INFORMANT <u>Pro Archie H. Rogers</u> Address <u>2014-05-28</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>L+4-3</u> DUE TO (b) <u>Hypertensive C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u> <u>5-7 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>11</u> p.m. <u>11</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>2/11/0</u> 196 <u>3</u> to <u>2/11</u> 196 <u>2</u> , that (I) (we) last saw the deceased alive on <u>2/11</u> 196 <u>2</u> and that death occurred at <u>12 Noon</u> from the causes and on the date stated above. 22a. SIGNATURE <u>H. T. O'HARLEY</u> M.D. <u>2/11/62</u> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>H. T. O'HARLEY</u> 22d. ADDRESS <u>5, Central Ave. Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Feb 14, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u> 23d. LOCATION (City, town or county) (State) <u>Galesville Md</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>T. A. Hardesty</u> ADDRESS <u>5, Central Ave. Glen Burnie, Md.</u> 25a. REC'D BY REGISTRAR <u>FEB 14 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

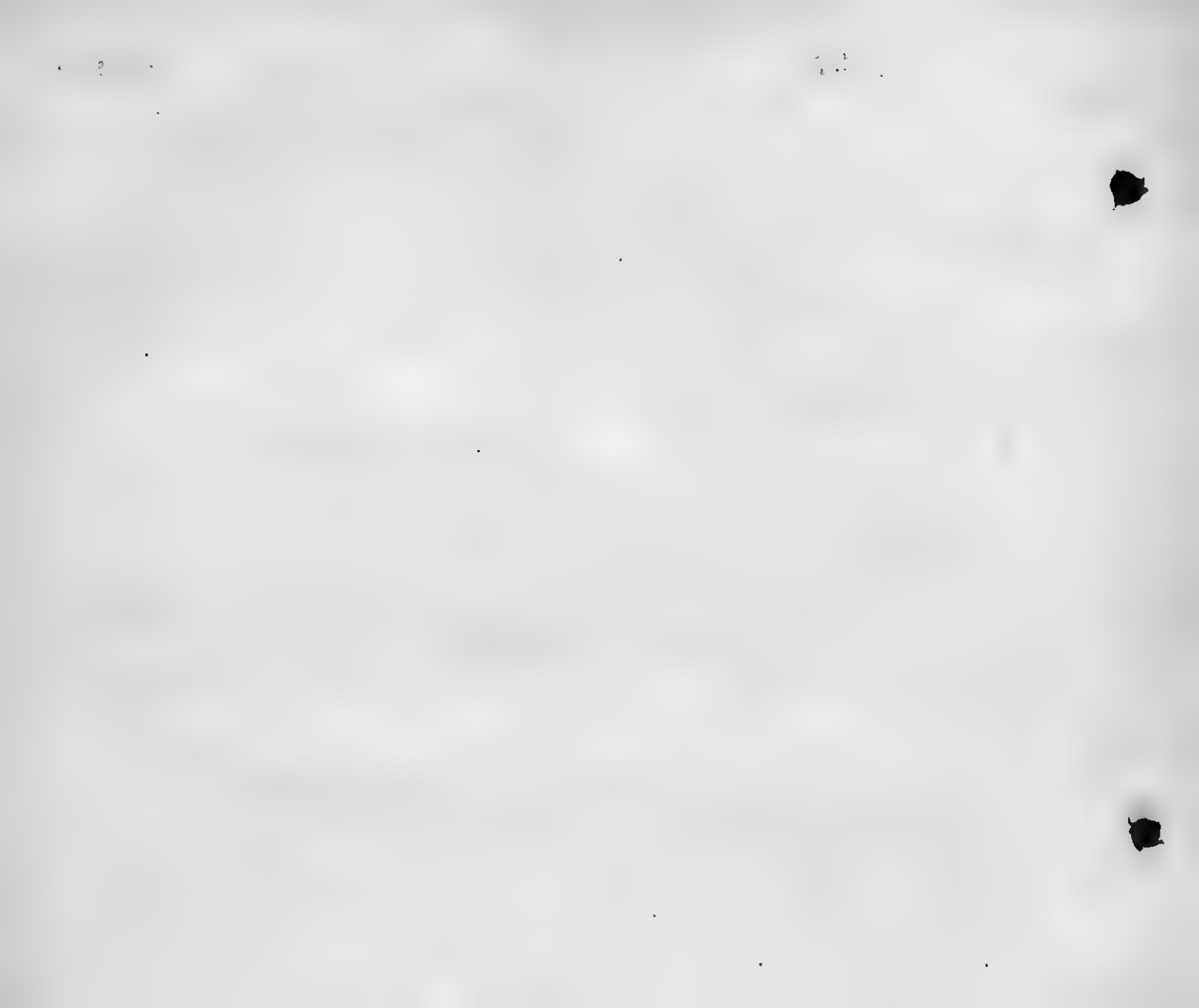
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01487

01471

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hanover, Md</b>		c. LENGTH OF STAY IN b <b>X</b> <b>Hanover, Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 114-D Dorsey Road</b>		d. STREET ADDRESS <b>Box 114-D Dorsey Road</b>	
3. NAME OF DECEASED (Type or print) <b>Martha P. Sanderson</b>		4. DATE OF DEATH <b>February 18 1962</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1878</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eden Flowers</b>		14. MOTHER'S MAIDEN NAME <b>Margaret (unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Travis A. Gibbs, Dorsey Road, Hanover, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute dehydration</b> <b>51X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>carcinoma of the stomach</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-16</b> , 1962 to <b>2-18</b> , 1962 that (I) (we) last saw the deceased alive on <b>2-18</b> , 1962 and that death occurred at <b>8:35</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>E. Roderick Shipley</b>			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>E. Roderick Shipley</b>			
22d. ADDRESS <b>529 Camp Meade Road.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-21-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</b>			
25a. REC'D BY REGISTRAR <b>DATE FEB 21 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01488

Item 2 Form 3508

2/5/62 JWL

01472

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Burnie</b>				c. LENGTH OF STAY IN 1b <b>17 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>				e. STREET ADDRESS <b>6 North Calhoun St.</b> <b>Baltimore City Hospitals</b>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Saro</b> Last				4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-14-1883</b>	
9. AGE (In years last birthday) <b>78 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-01-4403</b>		17. INFORMANT <b>Mr. Marani, Balto. D.P.W.</b>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma breast and colon</b> <b>194X</b> DUE TO <b>(Surgery in University Md. Hospital Sept. 1961)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardio renal vascular disease</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 9, 1960</b> to <b>Feb. 19, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 17, 1962</b> , and that death occurred at <b>5P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>James M. Pair</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-20-1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>				22d. ADDRESS <b>400 N. Carrollton Avenue Balto. 23 Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-23-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore County</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street, ZONE 2</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 26 '62</b>		25b. REGISTRAR'S SIGNATURE <b>2-23-62</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M III/59

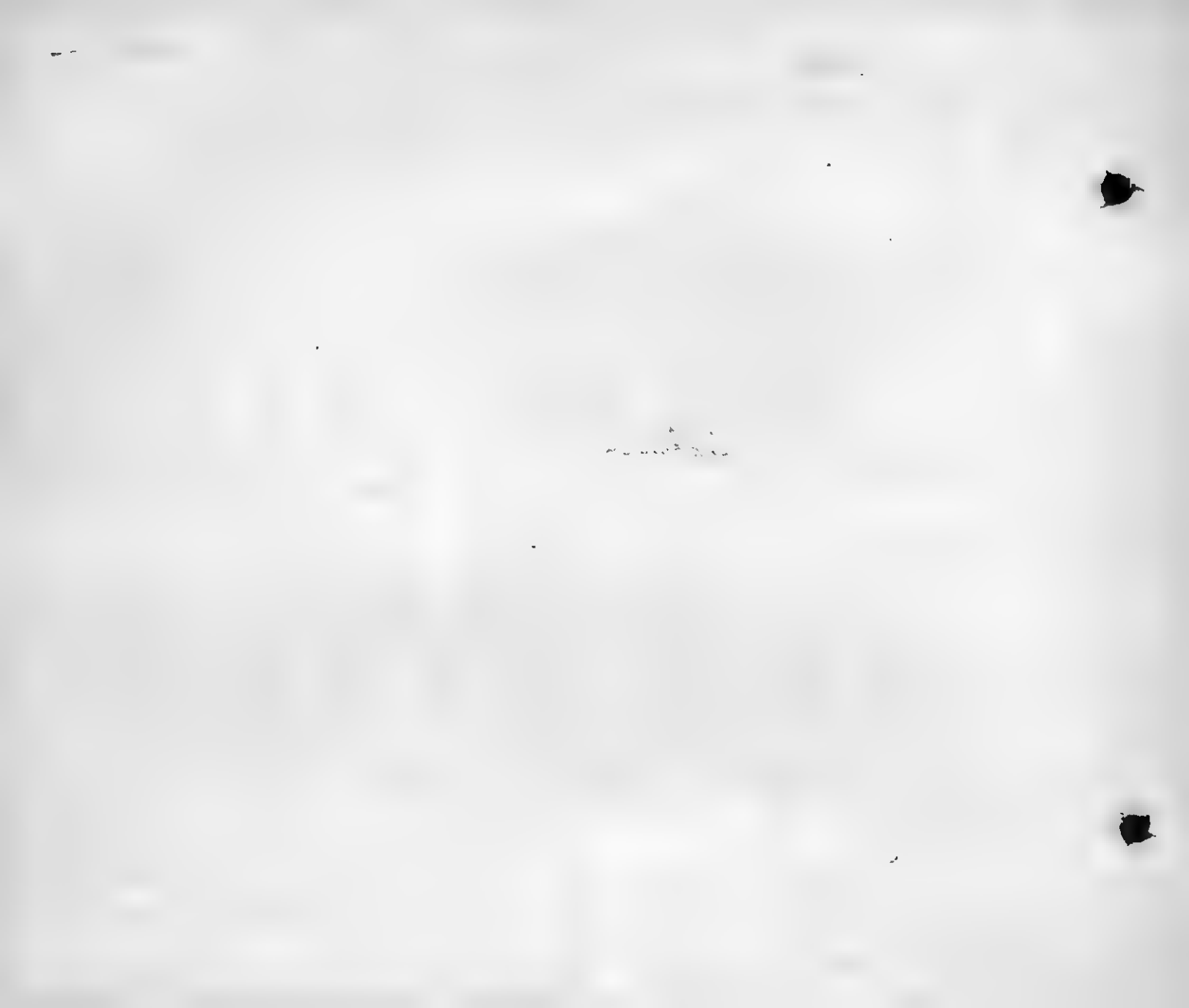
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01489

01473 -

1. PLACE OF DEATH a. COUNTY <u>Anne Arundell</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Anne Arundell</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>und</u>		d. STREET ADDRESS <u>103 Hollyberry</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Betty Bunnell Sassaman</u>		4. DATE OF DEATH <u>2-26-62</u> 19 <u>62</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3rd Nov. 1910</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Leithman Bunnell</u>		14. MOTHER'S MAIDEN NAME <u>Bertrude Stenken</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>2-5407-1831</u>	
17. INFORMANT <u>Kenneth Sassaman</u> Address <u>503 Kent Circle, Glen Burnie, Md.</u>		18. INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis C.V. Disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>1962</u> that (I) (we) last saw the deceased alive on <u>Jan 1962</u> and that death occurred at <u>8A</u> M. from the causes and on the date stated above			
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Hahn, M.D.</u>		22d. ADDRESS <u>Severna Park Md.</u>	
23a. BJR A., CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>28 Feb. '62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u>		23d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. T. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
25a. REC'D BY REGISTRAR <u>DATE FEB 28 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Frank</u>	

1





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01490 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01474

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Jessups</b> c. LENGTH OF STAY IN 1b <b>14 mos.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Maryland House of Correction</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>640 W. Franklin St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES H. SAWYER</b>			4. DATE OF DEATH Month Day Year <b>February 19 19 62</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/28/23</b>	9. AGE (in years last birthday) <b>38 yrs.</b>	IF UNDER 1 YEAR Months Days <b>38</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Elizabeth City, N.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>John</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Banks</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year and dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>237-03-11091</b>			17. INFORMANT Address <b>Maryland House of Correction Records</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> 443X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Partial</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Partial</b>			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Partial</b>	20f. (City or town) <b>Baltimore</b>	(County) <b>Baltimore</b>	(State) <b>Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL DEATH		Rudiger Breitenecker, M.D.		DATE SIGNED <b>Feb. 20, 1962</b>	
EXAMINER'S NAME (Type)		Rudiger Breitenecker, M.D.		Address (Street, city, town, or county) <b>Baltimore Md</b>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-26-62</b>	22c. NAME OF CEMETERY or CREMATORY <b>Mt Auburn</b>		22d. LOCATION (City, town, or country) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR <b>Adolphus Halstead</b>			ADDRESS <b>918 Druid Hill Ave.</b>		
24a. REC'D BY REGISTRAR <b>FEB 27 '62</b>			24b. REGISTRAR'S SIGNATURE <b>W. S. Kraus</b>		

MEDICAL CERTIFICATION



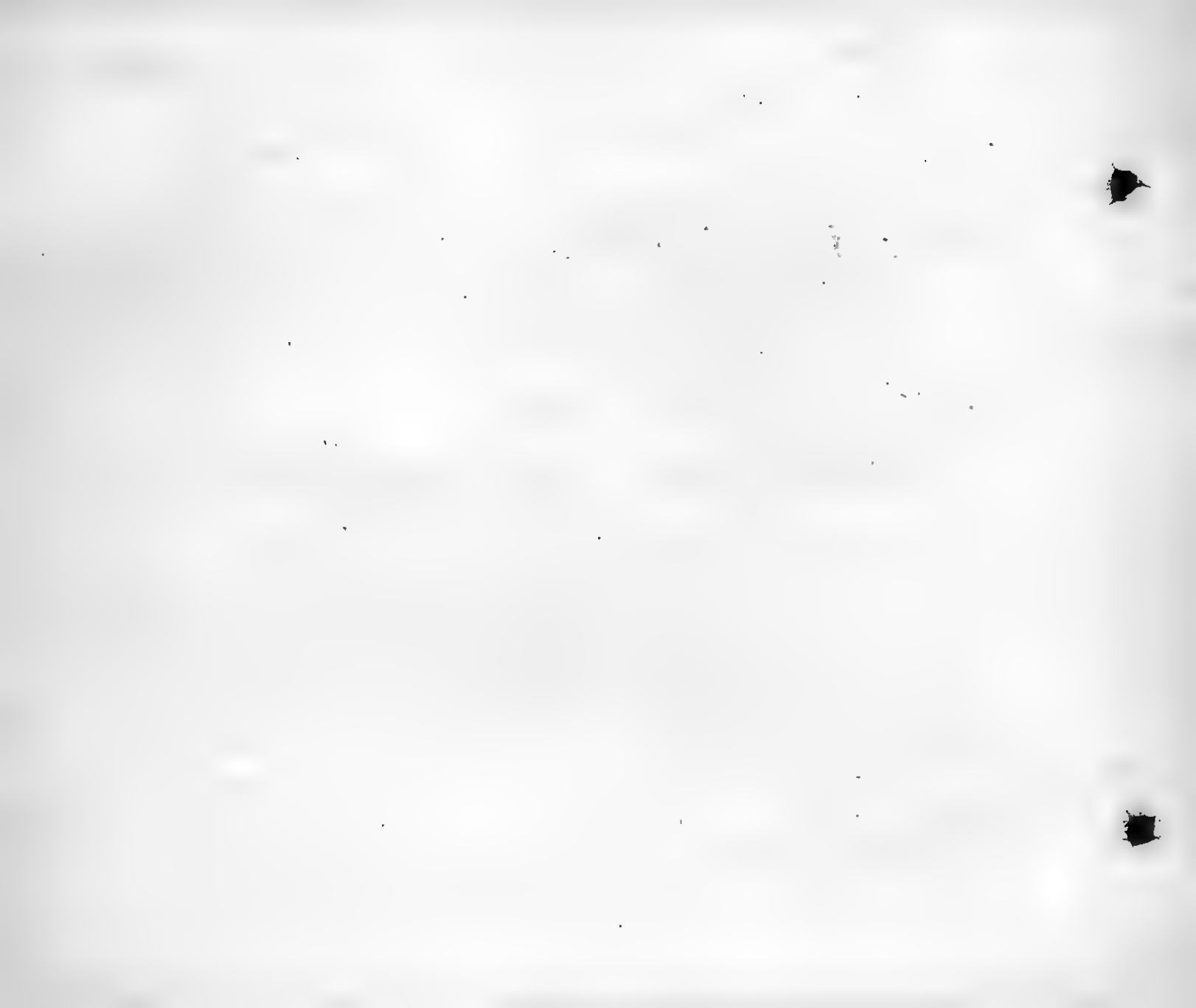
01491

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. 01475

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>HANOVER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X GLEN BURNIE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>607 BAYLOR RD.</b>		d. STREET ADDRESS <b>607 BAYLOR RD.</b>	
3. NAME OF DECEASED (Type or print) <b>ESTELLE M. SCHAEFER</b>		4. DATE OF DEATH <b>FEB 28 1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12/9/1905</b>
9. AGE (In years last birthday) <b>56</b> yrs		IF UNDER 1 YEAR: Months <b>28</b> Days <b>28</b> Hours <b>28</b> Min <b>28</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FREDERICK LITZ</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA LINK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>JAMES SCHAEFER SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.8</b> DUE TO <b>Carcinomatosis general</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of colon</b> (c) <b>17Yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>17Yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NO</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 1959</b> to <b>FEB 28 1962</b> , that I last saw the deceased alive on <b>FEB 20 1962</b> , and that death occurred at <b>10:00</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph Taler</b>		DATE SIGNED <b>2-28-62</b>	
PHYSICIAN'S NAME (Type) <b>JOSEPH TALER</b>		ADDRESS (Street, city or town, state) <b>102 BdA Blvd. N.E. GLENBURNIE, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/5/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LONDON PARK Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. G. Ruck Inc</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 2 '62</b>	
ADDRESS <b>5305 HARFORD RD.</b>		24b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

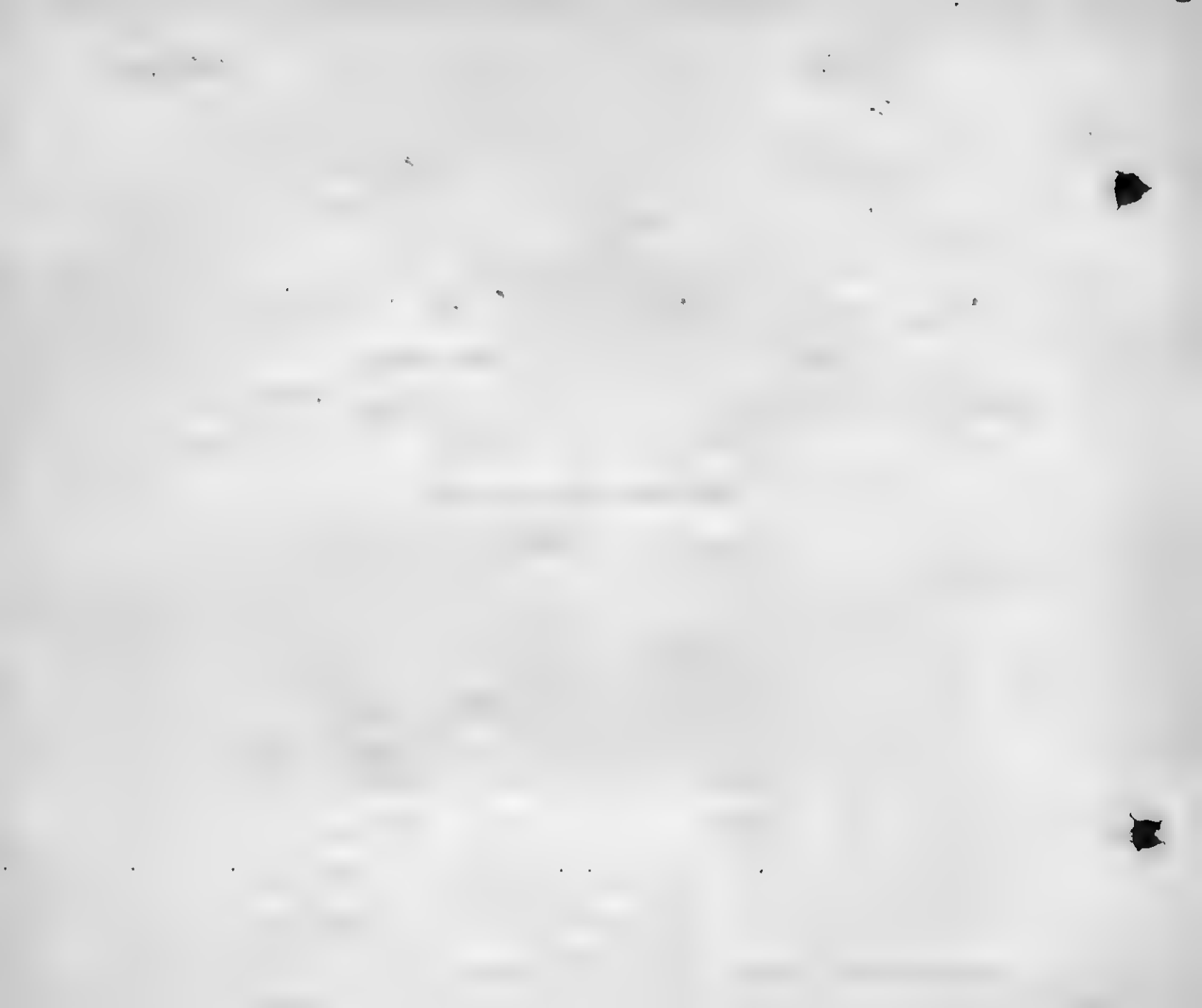
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01492

CERTIFICATE OF DEATH

01476

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brocklyn PK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>929 Hammond Ave</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brocklyn PK</u> d. STREET ADDRESS <u>929 Hammond Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Nora Ann</u> Middle <u>Schmidt</u> Last <u>Schmidt</u>		<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>17</u> Year <u>1962</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6-25-83</u>
<b>9. AGE</b> (In years last birthday) <u>78</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>	<b>11. IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MARYLAND</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>Sulin Stewart</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>IDA Huber</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Family</u>	
<b>17. INFORMANT</b> <u>Family</u>		<b>18. ADDRESS</b> <u>Some</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis C.V. disease</u> DUE TO (c)			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Terminal bronchopneumonia</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II. of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec 1952</u> <b>to</b> <u>2/17</u> <b>19</b> <u>62</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2/15</u> <b>19</b> <u>62</u> <b>and that death occurred at</b> <u>8:30 PM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Sidney R. Gehlert</u>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Sidney R. Gehlert, M.D.</u>		<b>22d. ADDRESS</b> <u>4700 Pennington Ave. Balto. #26, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>B</u>		<b>23b. DATE THEREOF</b> <u>2-20-62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cider Haven Cem</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Cider Haven Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>McCreedy Funeral Home</u>		<b>25a. REC'D BY REGISTRAR</b> <u>130 E. Fort Ave</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>2/17/62</u>		<b>25c. DATE</b> <u>FEB 20 '62</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician. Physicians may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

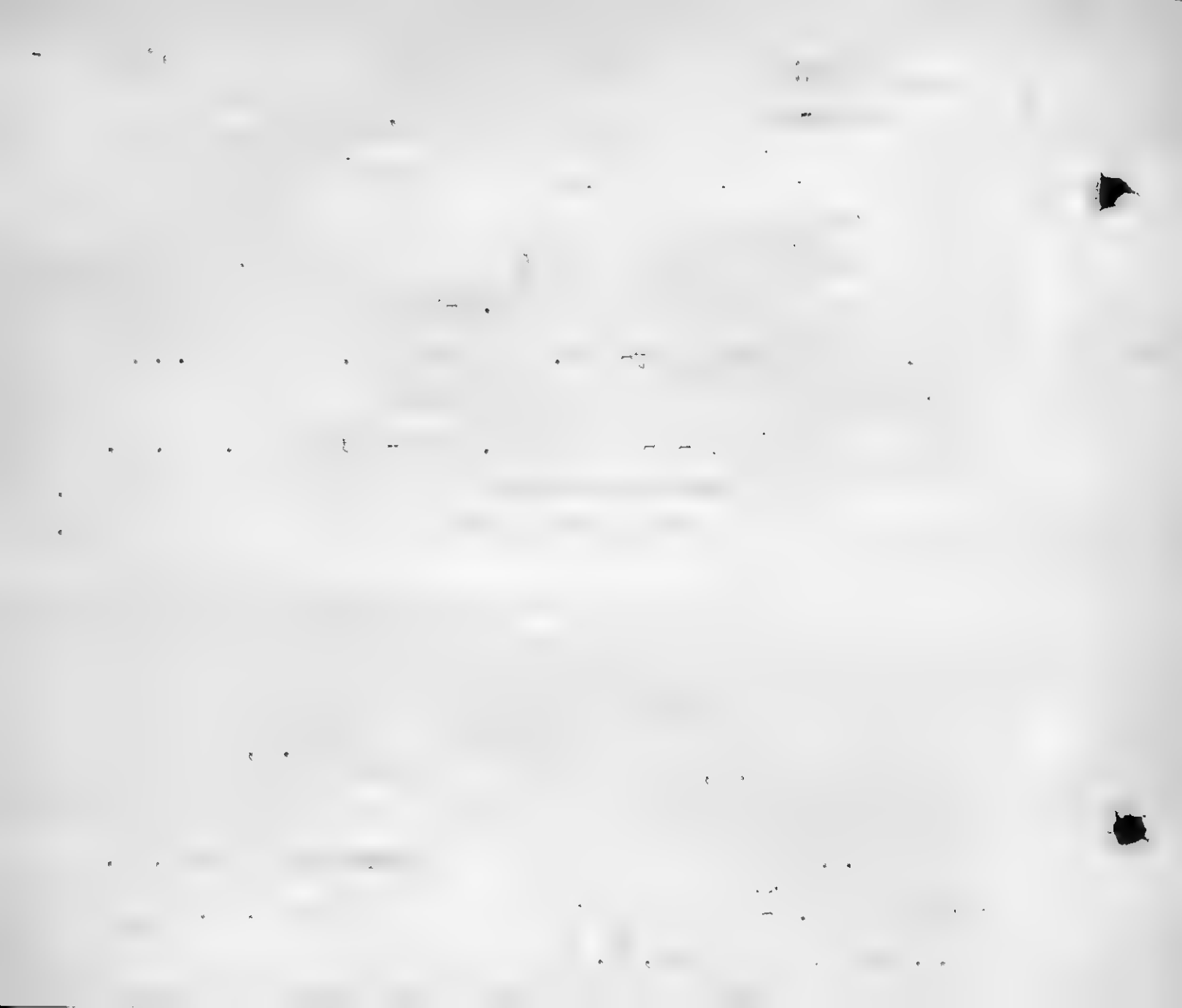
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01493

01477

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>59 Calvert Street</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>59 Calvert Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES ALBERT SCISCO</b> 5. SEX <b>M</b> 6. COLOR OR RACE <b>C</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Sept. 6-1883</b> 9. AGE (In years last birthday) <b>78</b> yrs. IF UNDER 1 YEAR: Months <b>4</b> Days <b>4</b> IF UNDER 24 HRS.: Hours <b>4</b> Min. <b>19 62</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gen. Utilities Retired Naval Acad.</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Annapolis, Md.</b> 11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Scisco</b> 14. MOTHER'S MAIDEN NAME <b>Sadie Sands</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>219-16-0100</b> 17. INFORMANT <b>Zora G. Scisco-59 Calvert St. Anna, Md.</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4 4 3 X</b> DUE TO <b>Hypertensive Sclerotic Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 9, 1957</b> , to <b>Feb. 4, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 4, 1962</b> , and that death occurred at <b>11 am</b> from the causes and on the date stated above		22a. SIGNATURE <b>Thodore H. Johnson M.D.</b> 22b. DATE SIGNED <b>2/6/62</b> 22c. PHYSICIAN'S NAME (Type) <b>T.H. Johnson</b> 22d. ADDRESS <b>Dean Street Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Feb. 8-62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b> 23d. LOCATION (City, town or county) (State) <b>Annapolis, Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hicks 111</b> ADDRESS <b>Annapolis, Md.</b> 25a. REC'D BY REGISTRAR <b>FEB 13 '62</b> 25b. REGISTRAR'S SIGNATURE <b>E. H. Hume</b>	





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01494

01478

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived, if institution, on residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>16 years</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dares Wharf</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>?</b>			
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>?</b> Last <b>Scott</b>				4. DATE OF DEATH Month <b>2</b> Day <b>13</b> Year <b>1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> <b>single</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		8. DATE OF BIRTH <b>October 23, 1923</b>	
9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>4</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Leroy Scott</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Parran</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>							
20c. TIME OF INJURY Hour a.m. p.m. <b>----- 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b> (County) <b>-----</b> (State) <b>-----</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3/26</b> ..... 19 <b>45</b> to <b>2/13</b> ..... 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> ..... 19 <b>62</b> , and that death occurred at <b>8:38 A.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>L. Benedict, M. D.</b>				22b. DATE SIGNED <b>2/13/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>				22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2-17-62</b>		23b. DATE THEREOF <b>2-17-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Plum Point</b>		23d. LOCATION (City, town or county) <b>Calvert</b> (State) <b>md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pinkney B. Sewell</b>				25a. REC'D BY REGISTRAR <b>Feb 20 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>Prince Frederick</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem may be retained by the hospital or attending physician, and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

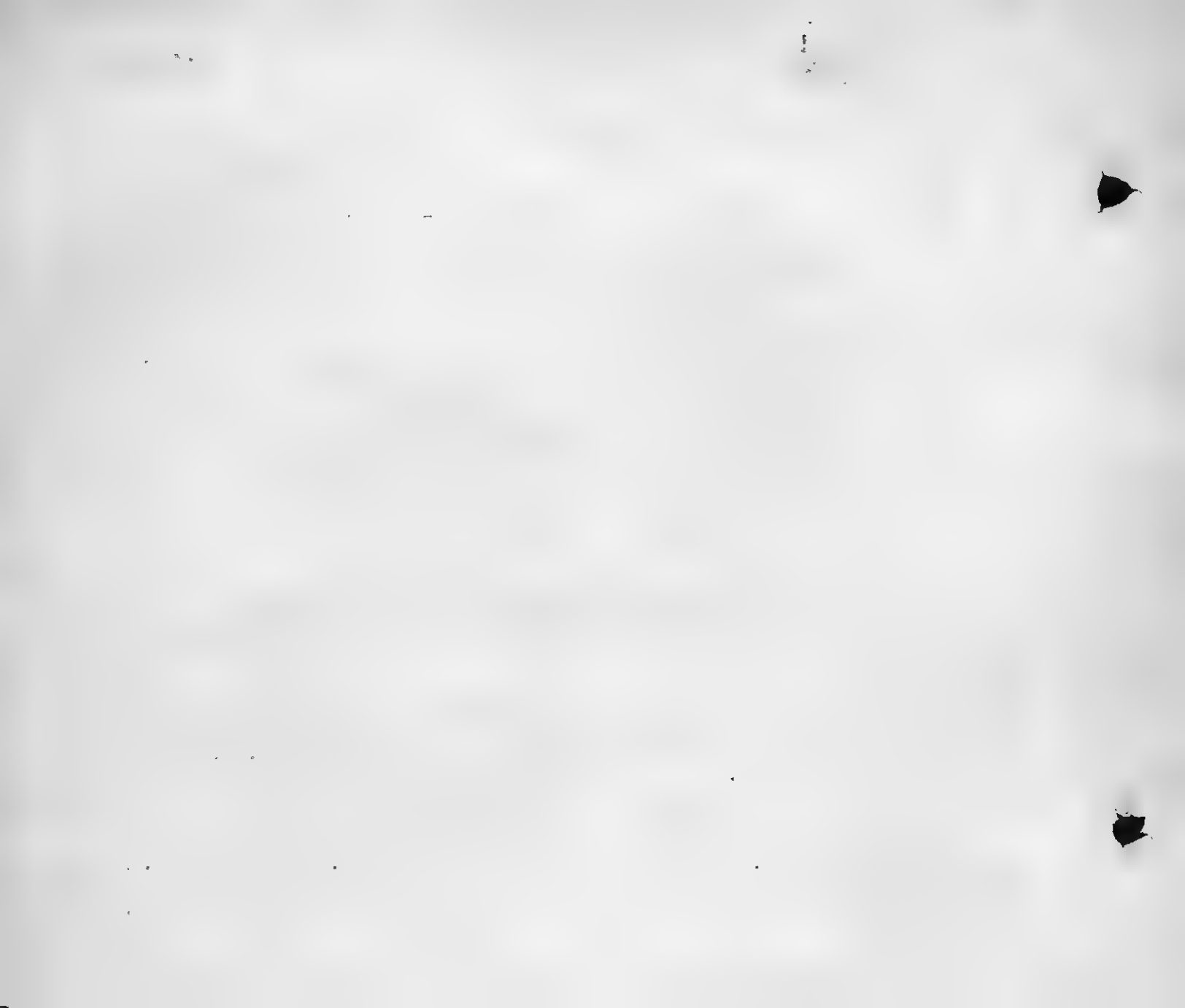
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01495

01479

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY in lb <u>8 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Edgewater</u>	
f. STREET ADDRESS <u>Rt-1, Box-333</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>E.</u> Last <u>SEITZINGER</u>		4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHARMACIST Ret. PHARMACIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PHARMACIST</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William M. Seitzinger</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Morse</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes W.W.I.</u>		16. SOCIAL SECURITY NO. <u>D. Evelyn Lingell</u>	
17. INFORMANT <u>Dr. Evelyn Lingell</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure due to metastatic carcinoma</u> 1577X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of the pancreas</u> (a), stating the underlying cause last. DUE TO (c) <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 3 weeks</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>Richard I. Hochman</u> attended the deceased from <u>Nov. 6, 1961</u> to <u>Feb. 1, 1962</u> that (I) <u>  </u> last saw the deceased alive on <u>Feb. 1, 1962</u> , and that death occurred at <u>11:10 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman</u>		22b. DATE SIGNED <u>2/2/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. HOCHMAN</u>		22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 5-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Annapolis National</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		25a. REC'D BY REGISTRAR <u>  </u>	
25b. REGISTRAR'S SIGNATURE <u>  </u>		DATE <u>FEB 5 '62</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01496

01480

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOMEWOOD Nursing Home</u>		e. STREET ADDRESS <u>111 MARKET ST</u>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>W.</u> Last <u>SHANNON</u>		4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-1880</u>
9. AGE (In years lost b. (day) yrs. <u>81</u>		IF UNDER 1 YEAR: Months <u>8</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seet-metal Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAHUEL WOOD</u>		14. MOTHER'S MAIDEN NAME <u>MARY F. COOPER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MARGARET T. BAKER #2</u>	
17. INFORMANT Address <u>MARGARET T. BAKER #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> +20 DUE TO (b) <u>10 YRS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>10 YRS</u> DUE TO (b) <u>10 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL THROMBOSIS (OLD)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH, 1960</u> to <u>2-15-1962</u> that (I) (we) last saw the deceased alive on <u>2-11-1962</u> and that death occurred at <u>11 AM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Edward S. Beck</u> M.D.		22b. DATE SIGNED <u>3/16/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>73 FRANKLIN ST ANNAPOLIS MD.</u>	
23a. BURIAL, CREMATION REMOVAL (Spec. 1) <u>BURIAL</u>		23b. DATE THEREOF <u>2-17-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		23d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 20 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Carlton L. Thomas</u>			



1  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01497

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01481

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN lb <b>28y.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1506 Gov. Ritchie Highway</b>				d. STREET ADDRESS <b>Same</b>	
3. NAME OF DECEASED (Type or print) <b>Thomas P. Shipley</b>		First Middle Last		4. DATE OF DEATH <b>February 5th. 19 62</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7/15/09</b>		9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk at the Md. Dry Dock</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Glen Burnie, Md.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Carl H. Shipley</b>		14. MOTHER'S MAIDEN NAME <b>Rose Pumphrey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-18-8736</b>		17. INFORMANT <b>Mrs. Clara Shipley (wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> + 20.1 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>2/6/62</b> <b>Glen Burnie, Md.</b>	
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>		EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		Address (Street, city, town, or county) <b>Glen Burnie, Md.</b>	
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8th Feb. '62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>	
22d. LOCATION (City, town, or country) <b>Glen Burnie, Maryland</b>		22e. REC'D BY REGISTRAR <b>Feb 13 '62</b>		22f. REGISTRAR'S SIGNATURE <b>G. H. Faubert</b>	

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## 1 Maryland STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01498

## CERTIFICATE OF DEATH

01482

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN IL <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel Gen. Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u> d. STREET ADDRESS <u>202 W. Hilltop Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rufus O. Simmons</u> First Middle Last 4. DATE OF DEATH <u>February 24, 1962</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 24, 1878</u> 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>William Simmons</u> 14. MOTHER'S MAIDEN NAME <u>Emma Ruark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>215-03-2903</u> 17. INFORMANT <u>Mrs. Hattie Simmons</u> Address <u>Same</u>		18. CAUSE OF DEATH [Enter on y one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio - Vascular Disease</u> (b) <u>Arterio - Sclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>1962</u> , that (I) (we) last saw the deceased alive on <u>1962</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Chas. L. Ball Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>Charles L. Ball Jr.</u> 22b. DATE SIGNED <u>Feb. 26, 1962</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>203 W Maple Road Linthicum, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Feb. 27, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u> 23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u> ADDRESS <u>4001 Ritchie Hwy. (25)</u> 25a. REC'D BY REGISTRAR <u>MAR 1 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

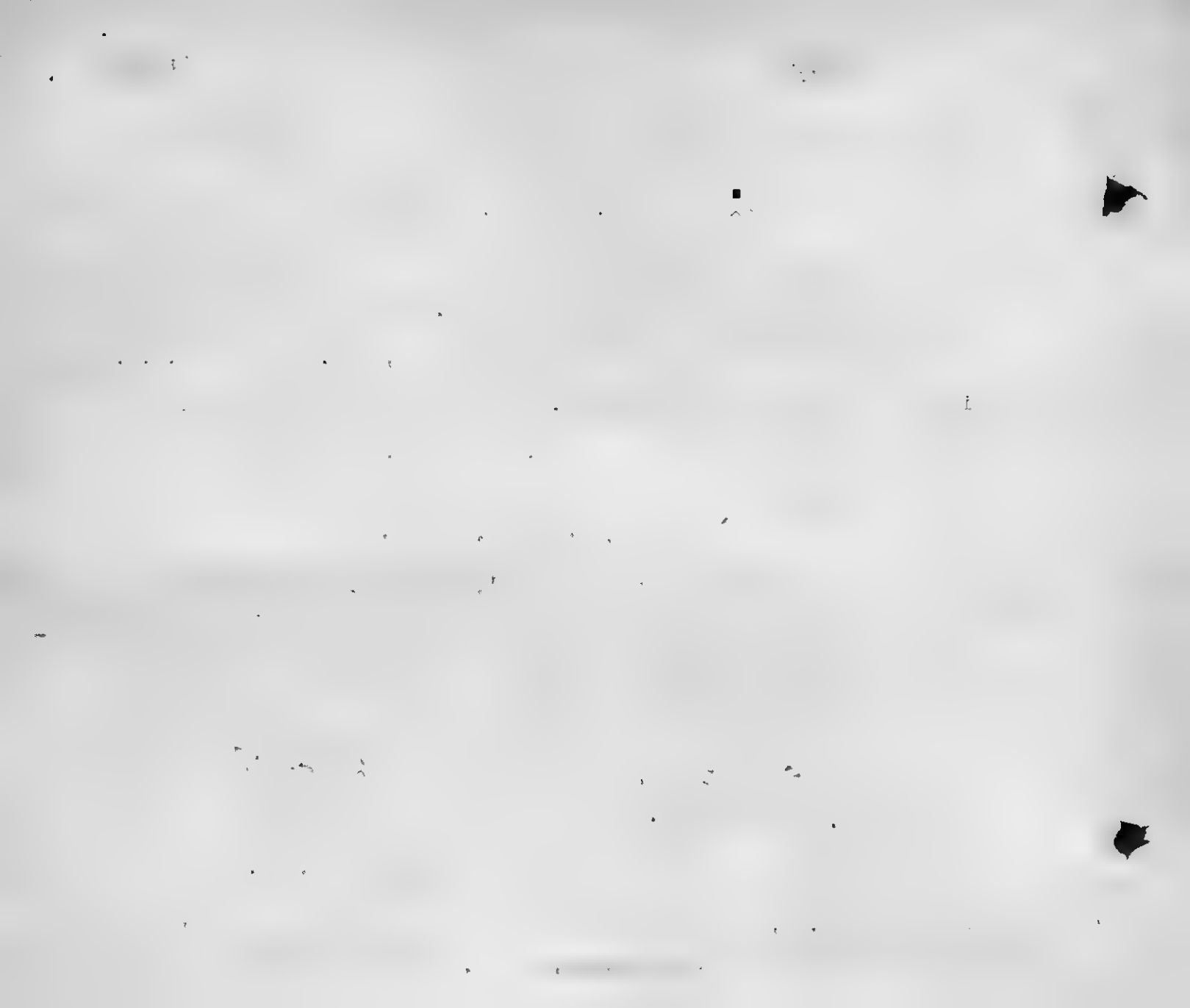
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01499

01483

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>48 Baltimore &amp; Annapolis Blvd.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> d. STREET ADDRESS <u>Rt. #2 Box 593A</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>WILLIAM CHARLES STINCHCOMB</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>4</u> Year <u>1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>29th Sept. '61</u>		<b>9. AGE</b> (In years last birthday) <u>4</u> <b>IF UNDER 1 YEAR</b> Months <u>4</u> Days <u>6</u> <b>IF UNDER 24 HRS.</b> Hours <u>6</u> Min. <u></u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Annapolis, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>William Charles Stinchcomb, Sr.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ethel Mae Marsteller</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>Mr. William C. Stinchcomb</u> <b>Address</b> <u>Same As #2</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Congenital Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Interval Between Onset and Death</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)							
<b>20c. TIME OF INJURY</b> Hour <u>11:40 AM</u> a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> <u>Severna Park, Md.</u>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept. 30, 1961</u> <b>to</b> <u>Feb. 7, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Feb. 7, 1962</u> <b>and that death occurred at</b> <u>11:40 AM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Clayton Norton</u>		<b>22b. DATE SIGNED</b> <u>Feb. 7, 1962</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Clayton Norton</u>			
<b>22d. ADDRESS</b> <u>Severna Park, Md.</u>		<b>22e. REC'D BY REGISTRAR</b> <input checked="" type="checkbox"/> <b>22f. REGISTRAR'S SIGNATURE</b> <u>Clayton L. Norton</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Feb. 6th, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Brooklyn, RFD, Maryland</u>		<b>23e. ADDRESS</b> <u>Glen Burnie, Md.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Richard T. Singleton</u>							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01500

Reg. 011484

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>63 Conduit St.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
3. NAME OF DECEASED (Type or print) First <u>Jewell</u> Middle <u>S</u> Last <u>Sullivan</u>		4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 10 1893</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James T. Small</u>		14. MOTHER'S MAIDEN NAME <u>Ella Jewell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Ella S. Colbert</u>	
17. INFORMANT <u>Ella S. Colbert</u> Address <u>(2)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hidden</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-24-1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 21 1962</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>8 Hines</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01501

## CERTIFICATE OF DEATH

01485

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Elizabeth's General Hospital</u>		d. STREET ADDRESS <u>140 Market St.</u>	
3. NAME OF DECEASED (Type or print) <u>Mills Kirby Summer</u>		4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-1900</u>
9. AGE (in years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carell Hall</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mills Summer</u>		14. MOTHER'S MAIDEN NAME <u>Lucretia A. Appleby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or both) <u>NO</u>		16. SOCIAL SECURITY NO. <u>140 Market St.</u>	
17. INFORMANT Address <u>Lucretia Snowden</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-2-1951</u> to <u>2-17-62</u> , that (I) (we) last saw the deceased alive on <u>2-15-62</u> , and that death occurred at <u>6 P</u> M. from the causes and on the date stated above			
22a. SIGNATURE <u>William T. Allen</u>		22b. DATE SIGNED <u>2-17-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM T. ALLEN</u>		22d. ADDRESS <u>612 Proctor St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-17-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Feb 16 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>William L. Finner</u>			

M





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01502  
7  
01486

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>1 year</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>895 Boyd Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Abrahn (Alias: Abraham) Taylor</b>		4. DATE OF DEATH Month Day Year <b>2 12 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 30, 1886</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Marlia</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-7000</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hemorrhage</b> <b>4142X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive Cardiovascular and Renal Disease</b> (c) DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m.----- p.m.----- <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from <b>1/3</b> 19 <b>58</b> to <b>2/12</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/12</b> 19 <b>62</b> , and that death occurred at <b>1:45</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. Benedict, M. D.</b>		22b. DATE SIGNED <b>2/13/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 17, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>W.H. Calkins Cem. Balto. Md.</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Katie R. Wilkerson</b>		25a. REC'D BY REGISTRAR <b>Schneider</b>	
25b. REGISTRAR'S SIGNATURE <b>Christina E. Jones</b>		DATE <b>FEB 19 '62</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

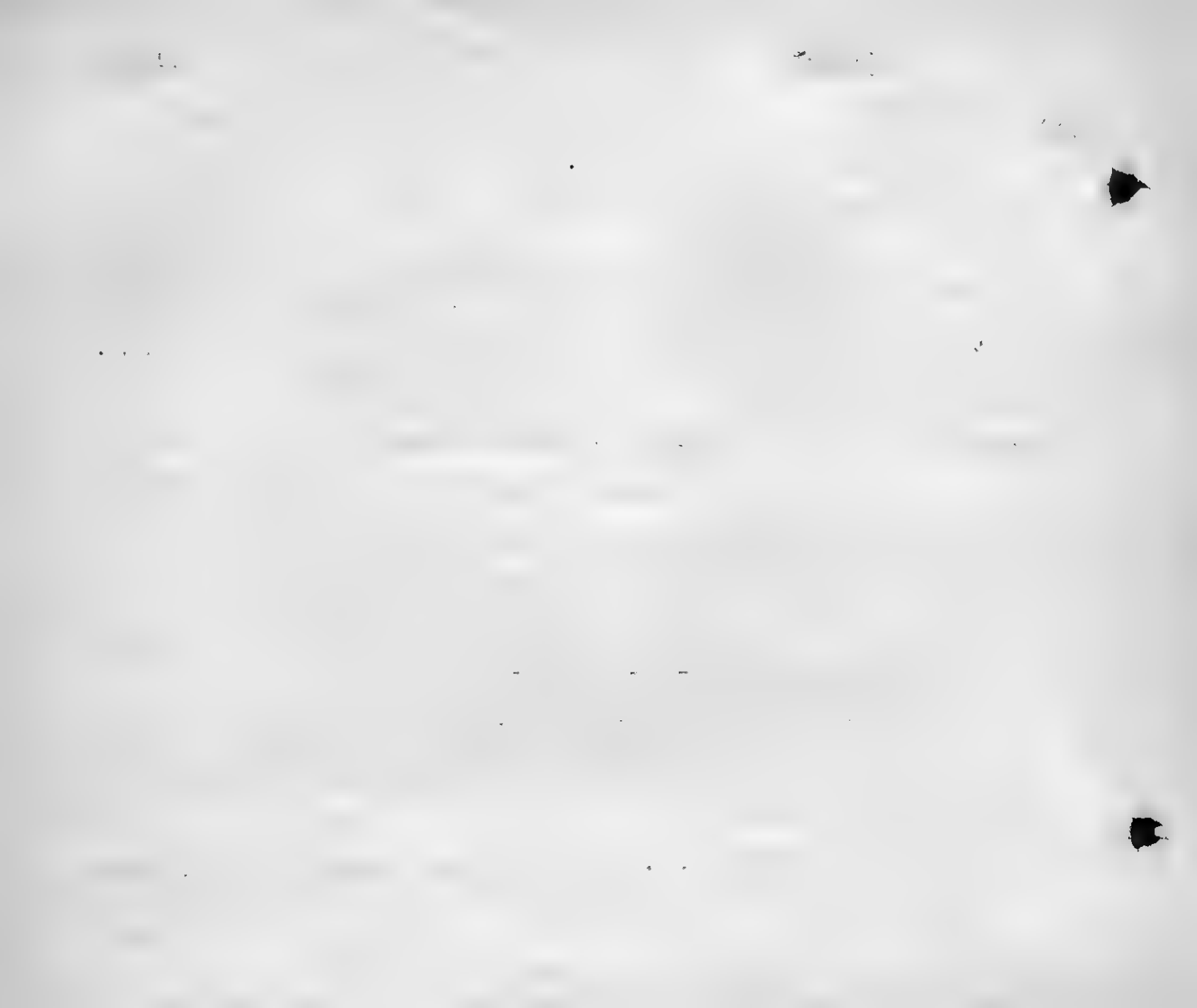
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01503

## CERTIFICATE OF DEATH

01487

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>1 day 1 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>733 Richmond Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Maria Taylor</b> First Middle Last 4. DATE OF DEATH <b>27 19 62</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>July 23, 1891</b> 9. AGE (In years last birthday) <b>70</b> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Williams</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b> 16. SOCIAL SECURITY NO. <b>219-05-8417</b> 17. INFORMANT <b>Hospital Records</b> Address		14. MOTHER'S MAIDEN NAME <b>Unknown</b> 18. CAUSE OF DEATH (Enter only one cause per line for a), (b) and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Occlusion</b> (a), stating the underlying cause last (c) <b>Coronary Arteriosclerosis</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <b>-----</b> 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. ----- p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b> 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>1/26</b> to <b>2/27</b> , 1962, that (I) (we) last saw the deceased alive on <b>2/27</b> , 1962, and that death occurred at <b>8:25</b> A.M. from the causes and on the date stated above. 22a. SIGNATURE <b>L. Benedict, M. D.</b> 22b. DATE SIGNED <b>2/27/62</b> 22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b> 22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>3/4/62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Greenacres</b> 23d. LOCATION (City, town or county) (State) <b>Wicomico Salisbury Md</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton H. Stewart By Salisbury Md</b> 25a. REC'D BY REGISTRAR <b>5 62</b> 25b. REGISTRAR'S SIGNATURE <b>Clifton H. Stewart</b> DATE <b>2/27/62</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH

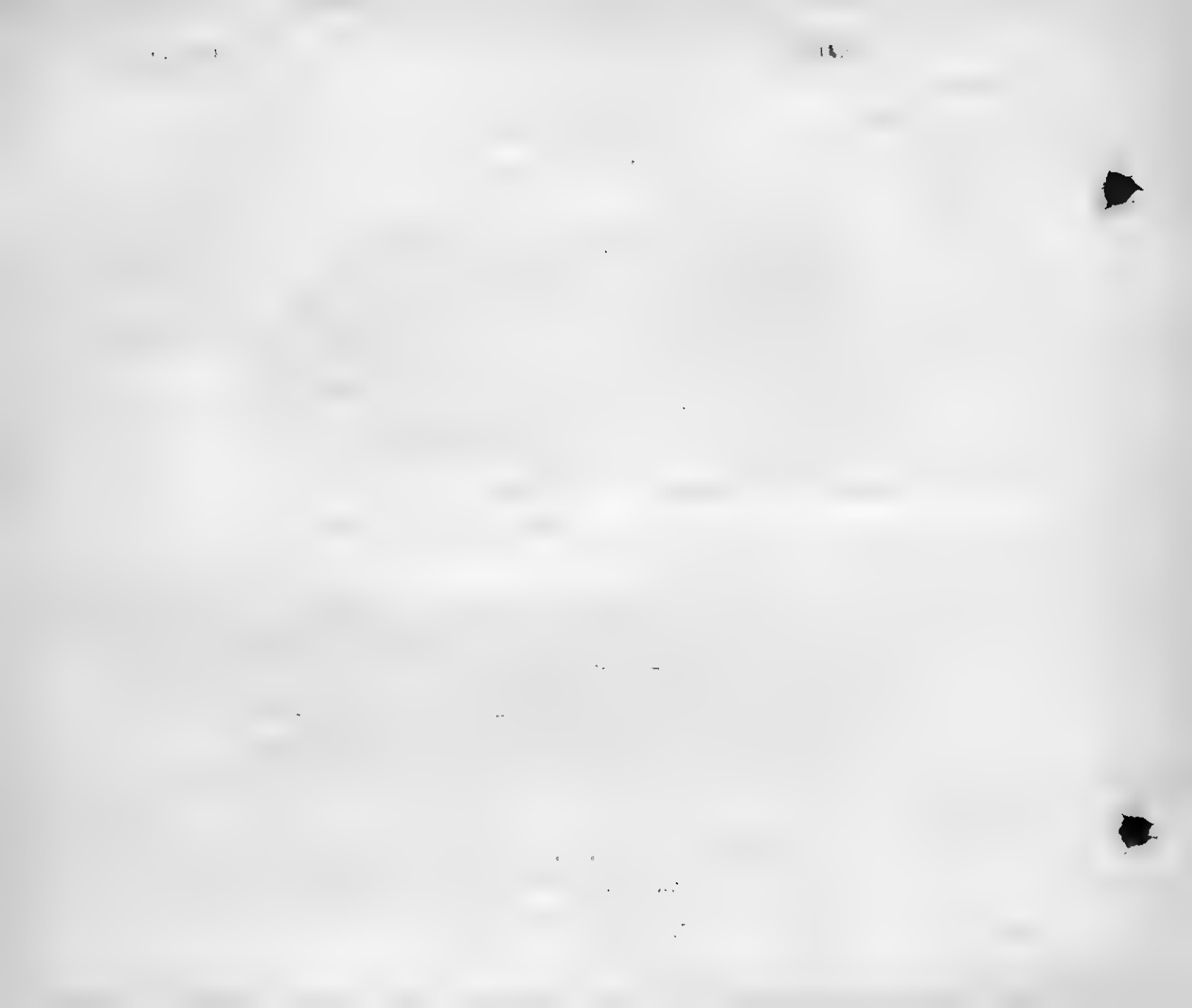
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01504

01488

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>2 mos. 14 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> d. STREET ADDRESS <b>Unknown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gladys</b> Middle <b>Pearl</b> Last <b>Thomas</b>		4. DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 8, 1916</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>45</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland - Rock Hall</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Martha Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 443X } DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive Cardiovascular Disease</b> (c) <b>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right Hemiplegia</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>-----</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State) <b>-----</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>12/14, 1961</b> , to <b>2/28, 1962</b> , that (I) (we) last saw the deceased alive on <b>2/28, 1962</b> , and that death occurred at <b>8:05 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lionel McHenry Mapp, M.D.</b>		22b. DATE SIGNED <b>3/1/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 5/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sharptown Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rock Hall, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin L. Wellman - Chestertown, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 6 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Thorne</b>			



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VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01505 CERTIFICATE OF DEATH 01489											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> , MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>P.G.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, <u>Churchton</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS <u>Churchton</u>					
3. NAME OF DECEASED (Type or print) <u>Keith Lamarr Thompson</u>						4. DATE OF DEATH <u>Feb. 3 1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 26-1961</u>		9. AGE (In years last birthday) <u>2</u> yrs. <u>2</u> months <u>3</u> days		IF UNDER 1 YEAR <u>2</u> months <u>3</u> days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County, State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thompson</u>						14. MOTHER'S MAIDEN NAME <u>Loretta B. Offer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. <u>Loretta B. Thompson Churchton Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> 5-71.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Infantile diarrhea (viral diarrhea)</u> DUE TO (c) <u>2 weeks</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1</u> , 19 <u>62</u> to <u>Feb. 3</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Feb. 2</u> , 19 <u>62</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Willard F. Smith</u> M.D.						22b. DATE SIGNED <u>2/3/62</u>					
22c. PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>						22d. ADDRESS <u>Shady Side, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2-5-1962</u>			23c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews</u>			23d. LOCATION (City, town or county) (State) <u>Shady Side Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese H. Anna, Md.</u>						25a. REC'D BY REGISTRAR <u>Feb 9 '62</u>			25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01506

CERTIFICATE OF DEATH

01490

1 PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Selby Edgewater</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Selby Edgewater</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIVER MARSH Guest House - RIVER NURSING HOME</u>		d. STREET ADDRESS <u>(on the Bay)</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eliza Fitzpatrick Tighe</u>		4. DATE OF DEATH Month Day Year <u>2 - 17 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug - 9th 1859</u>
9. AGE (In years lost birthday) yrs <u>102</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Fitzpatrick</u>		14. MOTHER'S MAIDEN NAME <u>Mary Marrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Mrs Robert S. Thorne</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lobar Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-11-1962</u> to <u>2-17-1962</u> that (I) (we) last saw the deceased alive on <u>2-16-1962</u> and that death occurred <u>1/2</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>Catharine St Annapolis Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-21-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HOLY SEPULCHER</u>		23d. LOCATION (City, town or county) (State) <u>EAST ORANGE N. J.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Sous Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 21 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>William J. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.

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12 1

MARYLAND STATE DEPARTMENT OF HEALTH

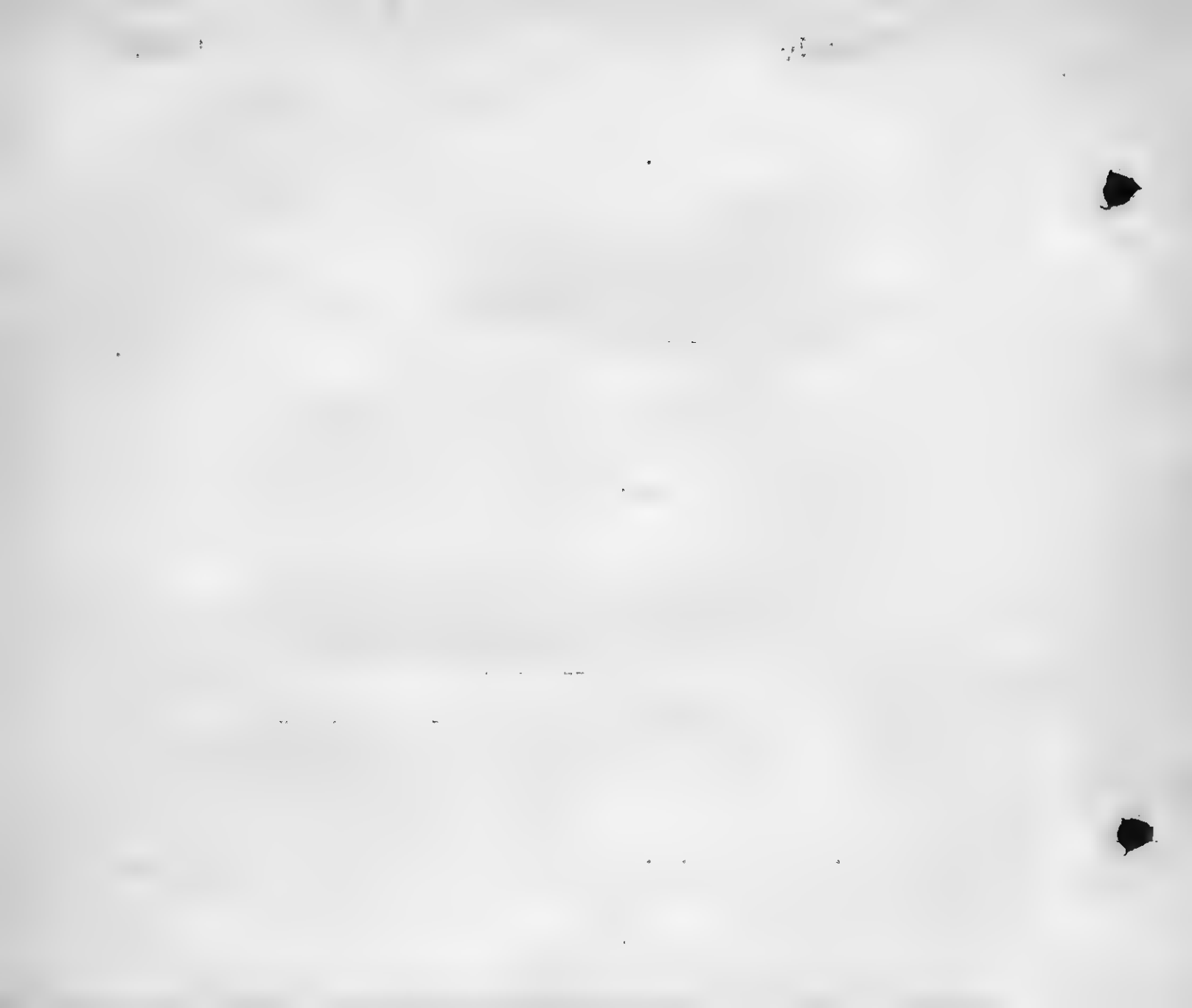
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01507

CERTIFICATE OF DEATH

01491

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>1 mo. 7 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1753 Mullekin Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>		3. NAME OF DECEASED (Type or print) <b>George</b>		First Middle Last <b>George</b>		4. DATE OF DEATH <b>Uzzle</b>		Month <b>2</b>		Day <b>12</b>		Year <b>19 62</b>		9. AGE (In years, last birthday) <b>60</b> yrs		10. UNDER 1 YEAR Months Days <b>60</b>		11. UNDER 24 HRS. Hours Min. <b>60</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 1, 1901</b>		9. AGE (In years, last birthday) <b>60</b> yrs		10. UNDER 1 YEAR Months Days <b>60</b>		11. UNDER 24 HRS. Hours Min. <b>60</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Uzzle</b>		14. MOTHER'S MAIDEN NAME <b>Susan</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>-----</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 304X DUE TO <b>Dehydration and Inanition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) <b>Dehydration and Inanition</b> (c) <b>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>-----</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>-----</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>8</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b>		20g. (County) <b>-----</b>		20h. (State) <b>-----</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <b>1/5/62</b> to <b>2/12/62</b> , that (I) (we) last saw the deceased alive on <b>2/12/62</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>L. Benedict, M. D.</b>		22b. DATE SIGNED <b>2/13/62</b>		22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>		22e. REC'D BY REGISTRAR <b>-----</b>		22f. REGISTRAR'S SIGNATURE <b>-----</b>		22g. DATE <b>FEB 14 '62</b>		22h. REGISTRAR'S SIGNATURE <b>-----</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/17/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. Auburn Cem.</b>		23d. LOCATION (City, town or county) <b>Westport</b>		23e. (State) <b>Md.</b>		23f. REC'D BY REGISTRAR <b>-----</b>		23g. REGISTRAR'S SIGNATURE <b>-----</b>		23h. DATE <b>FEB 14 '62</b>		23i. REGISTRAR'S SIGNATURE <b>-----</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Wilson</b>		24a. ADDRESS <b>1000 Braithley Ave.</b>		24b. DATE <b>FEB 14 '62</b>		24c. REGISTRAR'S SIGNATURE <b>-----</b>		24d. DATE <b>FEB 14 '62</b>		24e. REGISTRAR'S SIGNATURE <b>-----</b>		24f. DATE <b>FEB 14 '62</b>		24g. REGISTRAR'S SIGNATURE <b>-----</b>		24h. DATE <b>FEB 14 '62</b>			



01508

## CERTIFICATE OF DEATH

01492

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. LENGTH OF STAY IN 1b <b>10</b> <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>320 Locust Ave.</b>				d. STREET ADDRESS <b>320 Locust Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DELORES ACHENBACK VANYO</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>24</b> Year <b>19 62</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1906</b>		9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>_____</b>				14. MOTHER'S MAIDEN NAME <b>_____</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Stephen R. Vanyo - Husband - same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Cardiac Dehydration</b> <b>260X</b> DUE TO <b>(Diabetes Mellitus)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized carcinoma metastases</b> DUE TO <b>Carcinoma of the Pancreas</b> (c) <b>_____</b>						INTERVAL BETWEEN ONSET AND DEATH <b>_____</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>_____</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11</b> <b>1961</b> to <b>2124</b> <b>1962</b> , that I last saw the deceased alive on <b>7/24</b> <b>1962</b> , and that death occurred at <b>12:30 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Albert L. Anderson</b> M.D.				ADDRESS (Street, city or town, state) <b>44 Southgate Ave. Annapolis, Md.</b> DATE SIGNED <b>7/24/62</b>			
PHYSICIAN'S NAME (Type) <b>Albert L. Anderson MD</b>				Southgate Ave, Annapolis, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 26, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b> ADDRESS <b>Annapolis, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 27 '62</b>		24b. REGISTRAR'S SIGNATURE <b>C. S. P. Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01509

01493

<b>1. PLACE OF DEATH</b> a. COUNTY <b>A.A.</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>113 Ferndale Road</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A.A.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>3 Ferndale Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Elizabeth R Voorhese</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>February 13 19 62</b>		<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 25, 1892</b>		<b>9. AGE</b> (In years last birthday) <b>69</b> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min.</th> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>South Carolina</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>											
<b>13. FATHER'S NAME</b> <b>Samuel K. Galloway</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Alice Cliburn</b>																	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>none</b>				<b>17. INFORMANT</b> <b>Wm.C.Voorhese, 113 Ferndale Road, Glen Burnie, Md</b>													
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Failure</b> DUE TO <b>Ca of Pneumonia &amp; metastases</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>arterio-sclerotic C.V.R. &amp;</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 day</b> <b>1 yr</b> <b>2 yrs</b>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>										<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>11/9</b> <b>19</b> <b>61</b> , <b>to</b> <b>2/13</b> <b>19</b> <b>62</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>2/13</b> <b>19</b> <b>62</b> , <b>and that death occurred at</b> <b>3 PM</b> , <b>from the causes and on the date stated above.</b>																					
<b>22a. SIGNATURE</b> <b>Joseph G. Laukaitis M.D.</b>										<b>22b. DATE SIGNED</b> <b>2/4/62</b>											
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Joseph G. Laukaitis, M.D.</b>										<b>22d. ADDRESS</b> <b>679 Washington Blvd., Baltimore 30</b>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>2-15-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>New Cathedral Cemetery</b>		<b>23d. LOCATION (City, town or county)</b> <b>Baltimore, Maryland</b>		<b>(State)</b>													
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</b>										<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 16 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hanna</b>									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01510

01494

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Green Haven</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Green Haven</b>	
c. LENGTH OF STAY in tb <b>20 yrs.</b>		d. STREET ADDRESS <b>3rd. Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3rd Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Catherine Warfield</b>		4. DATE OF DEATH <b>February 19, 1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 14, 1883</b>	
9. AGE (in years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Cook</b>		14. MOTHER'S MAIDEN NAME <b>Catherine</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Mr. Allen T. Warfield</b>	
17. INFORMANT <b>Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Arterio Sclerosis</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan., 1955</b> to <b>Feb. 19, 1962</b> that (I) (we) last saw the deceased alive on <b>Feb. 19, 1962</b> and that death occurred at <b>10:25 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J. Brady Smith</b>			
22b. DATE SIGNED <b>Feb. 20, 1962</b>			
22c. PHYSICIAN'S NAME (Type) <b>Brady Smith M.D.</b>			
22d. ADDRESS <b>Riviera Beach, A. A. Co., Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>Feb. 22, 1962</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>			
23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce</b>			
ADDRESS <b>4001 Ritchie Hwy. (25)</b>			
25a. REC'D BY REGISTRAR <b>DATE FEB 27 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>C. L. L. L.</b>			

VR A15 (4)  
ISM 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01511

01495

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>AA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Benfield Rd - Millersville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kushwood Manor</u>		d. STREET ADDRESS <u>—</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Rosin Watson</u>		4. DATE OF DEATH Month Day Year <u>2-13-62</u> 19 <u>62</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 16, 1881</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Stillpond md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wm. S. Rosin</u>		14. MOTHER'S MAIDEN NAME <u>Angie Warren</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>H. James Watson Benfield Rd, Millersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>+ 43</u> DUE TO (b) <u>Hypertensive C.V. disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Gen. arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>1962</u> that (I) (we) last saw the deceased alive on <u>2-8-1962</u> and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.		22b. DATE SIGNED <u>2-13-62</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>Robert R. Hahn</u>		22d. ADDRESS <u>Severna Park Md</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-15-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>STILL POND CEMT</u>		23d. LOCATION (City, town, or county) (State) <u>STILL POND, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u> ADDRESS <u>STILL POND, MD.</u>		25a. REC'D BY REGISTRAR <u>—</u> DATE <u>FEB 16 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>—</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>40 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>607 Pennsylvania Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>D</u> Last <u>WILLIAMS</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/7/1910</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u>		11. IF UNDER 24 HRS. Hours <u>11</u> Min. <u>15</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
<u>TRUCK DRIVER</u>				<u>Baltimore, Md</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Georgia</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>218-05-7901</u>			
17. INFORMANT <u>Address</u>							
18. CAUSE OF DEATH (Enter on y one cause only for (a) (b) and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO <u>Hypertensive Cardiovascular Renal Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerosis</u> DUE TO <u>Syphilis and Chronic Brain Syndrome due to Cerebral Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)							
20c. TIME OF INJURY Month, Day, Year <u>19</u>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1/3/62</u> to <u>2/12/62</u> , that (I) (we) last saw the deceased alive on <u>1/3/62</u> , and that death occurred at <u>11/3/62</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Lionel M. Henry Mapp</u>							
22b. DATE SIGNED <u>2/12/62</u>							
22c. PHYSICIAN'S NAME (Type) <u>Lionel M. Henry Mapp</u>							
22d. ADDRESS <u>Crownsville State Hospital Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)							
23b. DATE THEREOF <u>2/15/62</u>							
23c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony's</u>							
23d. LOCATION (City, town or country) (State) <u>Baltimore Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frances H. Hardy</u>							
25. REC'D BY REGISTRAR <u>Arthur S. Harris</u>							
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>							
25c. DATE <u>FEB 16 '62</u>							

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

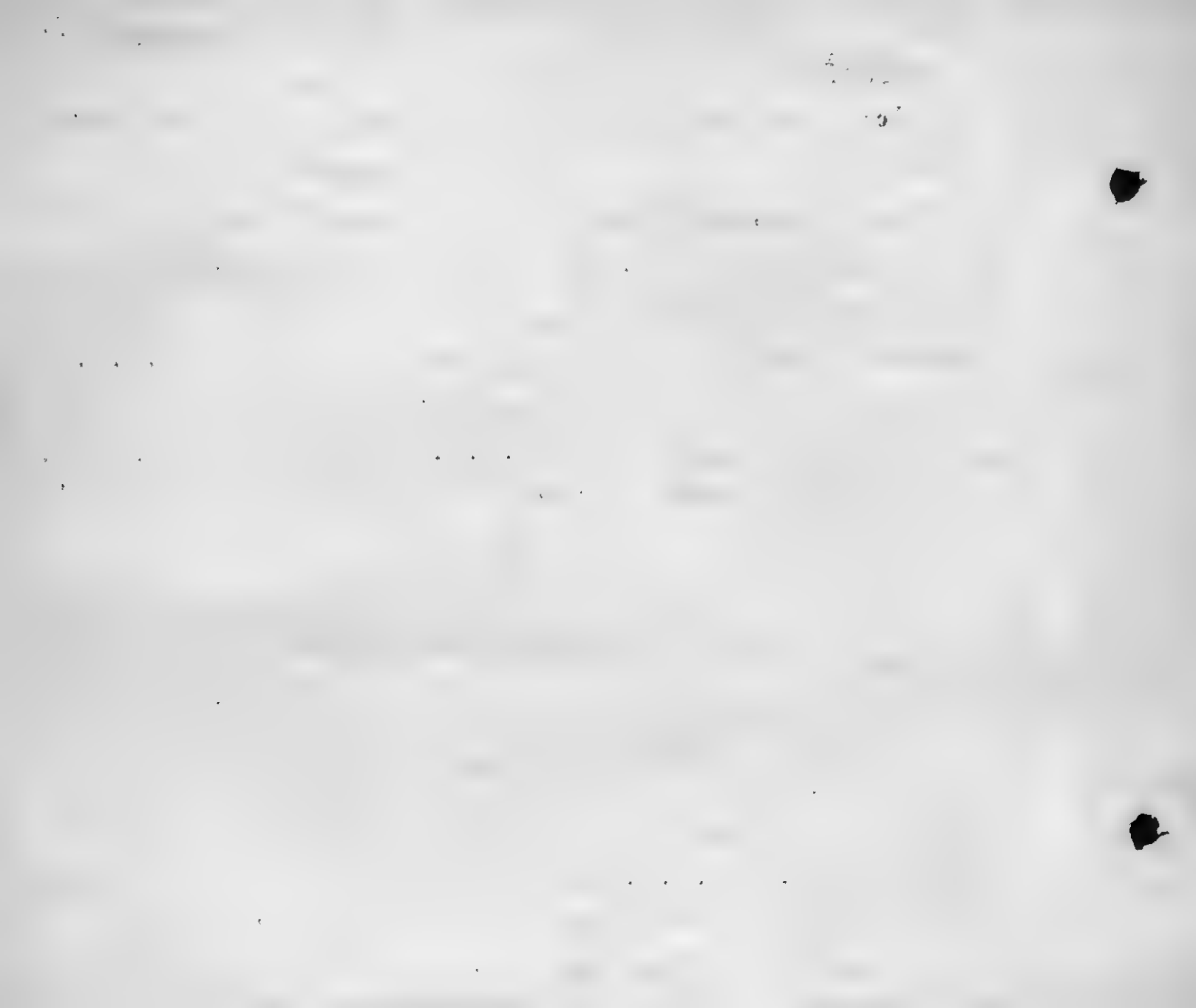
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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01513

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25</u>			
c. LENGTH OF STAY IN IS				d. STREET ADDRESS <u>603 Regatta Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>603 Regatta Avenue, Terrace View</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>KURT P. WISE</u>				4. DATE OF DEATH <u>February 21, 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/20/92</u>	
9. AGE (in years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>69</u> Days <u>69</u>		IF UNDER 24 HRS. Hours <u>69</u> Min. <u>69</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Draftsman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William Wise</u>				14. MOTHER'S MAIDEN NAME <u>Simon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>[If yes give year or dates of service]</u>				16. SOCIAL SECURITY NO. <u>Mrs. H. P. Packert, 2308 Poplar Dr., Balto. 7</u>			
17. INFORMANT Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of Liver</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>[ ]</u> (a), stating the underlying cause last. DUE TO (c) <u>[ ]</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Howard G. Shaub</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>HOWARD G. SHAUB, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>2/24/62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>				22d. LOCATION (City, town, or country) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR ADDRESS <u>Ellsworth Armacost 4600 Liberty Heights Ave.</u>				24a. REC'D BY REGISTRAR <u>FEB 27 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>			

DATE SIGNED  
2/22/62





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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

01498

01514

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>2yrs.10 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>		d. STREET ADDRESS <b>Rt.2 Holly Beach Farm</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John Wright</b>		4. DATE OF DEATH <b>February 23, 1962</b>	
S. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-11-1871</b>	
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR: Months <b>90</b> Days <b>90</b> Hours <b>90</b> Min. <b>90</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Race horse caretaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Racing Stable</b>	
11. BIRTHPLACE (State or foreign country) <b>Bedford County, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Katie Wright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-18-7827A</b>	
17. INFORMANT <b>Mrs. H.A.Parr, 111 Rt.2 Holly Beach Farm, Annap.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meatastatic pulmonary carcinoma</b> DUE TO (b) <b>Carcinoma of prostate</b> DUE TO (c) <b>1777x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.?</b> <b>3 yrs. ?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-6-1960</b> 19 to <b>2-23-1962</b> 19, that (I) (we) saw the deceased alive on <b>2-17-1962</b> 19, and that death occurred at <b>10PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James M. Pair</b>		22b. DATE SIGNED <b>2-124-1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>		22d. ADDRESS <b>400 N. Carrollton Ave. Balto.23,Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-27-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARYS</b>		23d. LOCATION (City, town, or county) (State) <b>ANNAPOLIS - MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. HICK III Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 2 '62</b>	
ADDRESS <b>Annapolis</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Phipps</b>	

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## CERTIFICATE OF DEATH

Reg. Dis. No. **01499**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. LENGTH OF STAY IN 1b <b>10</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		d. STREET ADDRESS <b>1993 Fairfax Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Knowltingwood Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SYLVESTER</b> Middle <b>CARL</b> Last <b>YOUNGREN</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>24</b> , Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1886</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USN</b>	11. BIRTHPLACE (State or foreign country) <b>Boston, Mass</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs Lottie G. Youngren- Wife- same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac failure</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>arterio-sclerotic heart disease</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/14/62</b> , 19 <b>62</b> , to <b>2/24</b> , 19 <b>62</b> ; that I last saw the deceased alive on <b>2/19</b> , 19 <b>62</b> , and that death occurred at <b>11:00</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>G. Church</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Gerard Church MD</b> <b>121 Cathedral Street, Annapolis, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>February 27, 62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 27 '62</b>	
ADDRESS <b>Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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1911

DECEASED

NAME

RESIDENCE

AGE

SEX

RACE

CAUSE

DATE

DECEASED

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